



DEPARTMENT OF HEALTH
AND SOCIAL SECURITY

REPORT OF THE COMMITTEE ON NURSING

Chairman
PROFESSOR ASA BRIGGS

*Presented to Parliament by the Secretary of State for Social Services,
the Secretary of State for Scotland
and the Secretary of State for Wales
by Command of Her Majesty
October 1972*

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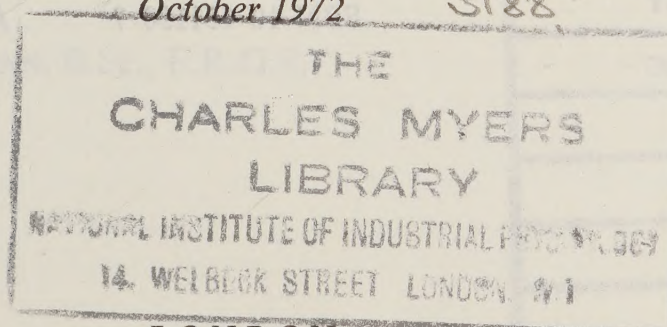
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¹ Appointed 29/7/1970; resigned to take up appointment at the D.H.S.S. 31/8/1971.

² Appointed 4/9/1970.

³ Appointed 9/2/1971.

⁴ Appointed 28/6/1971.

⁵ Resigned for personal reasons 26/10/1970.

CHAIRMAN'S PREFACE

To: The RIGHT HONOURABLE SIR KEITH JOSEPH, Baronet, M.P.

Secretary of State for Social Services

The RIGHT HONOURABLE GORDON CAMPBELL, M.C., M.P.

Secretary of State for Scotland

The RIGHT HONOURABLE PETER THOMAS, Q.C., M.P.

Secretary of State for Wales

Our appointment was announced in Parliament by the then Secretary of State for Social Services, Mr. Richard Crossman, on 2 March 1970. Our terms of reference were as follows:—

“To review the role of the nurse and the midwife in the hospital and the community and the education and training required for that role, so that the best use is made of available manpower to meet present needs and the needs of an integrated health service.”

We met as a Committee for the first time on 12 June 1970 and have subsequently met in main Committee sessions, including some week-end sessions, twenty-one times, excluding sessions devoted entirely to the taking of oral evidence. On each occasion all or almost all members have attended our meetings. They have also been actively involved in a network of related activities. During the course of our work we have relied on nineteen Sub-Committees or Working Groups and upon contributions, often of the greatest value, from individual members of the Committee. Representative groups of members have also visited hospitals, local health authorities and educational establishments in all parts of Great Britain, as many as we were able to visit within the time available to us. (A list of places visited is printed in Appendix III.) The opportunity of hearing the views of the different people whom we met on our visits has been invaluable, and the hospitality offered us was always warm and encouraging. I am deeply grateful, myself, to the members of our Committee for the thoughtful and energetic way in which they have devoted themselves to its very varied tasks and for their willing cooperation, despite all their other responsibilities, personal and public, in following the difficult timetable we deliberately set ourselves.

From our first meeting onwards we were fortunate in being able to draw upon the services as research officers of Dr. Jillian MacGuire and Mr. Nicholas Bosanquet. We have been greatly helped also throughout most of our period of enquiry by Mr. Richard Clifton and Mr. Kenneth Jarrold and for part of our enquiry by Mr. Brian Merriman and Miss Christine Hancock. On most of our visits we have been accompanied by members of this research team who have also attended most of our meetings. We would like to thank them for the careful attention which they have given to the work of the Committee at every stage.

Likewise, we owe a debt to our observers and advisers from the different Departments directly concerned with our work. It would be invidious to mention individual names, but we have depended on them at many points for information which otherwise would have been inaccessible to us and for the kind of contributions to our deliberations which have enabled us to make speedy progress.

In the course of our enquiries we collected evidence from a wide range of bodies and commissioned pieces of research. A list of the people and organisations who gave oral and written evidence is printed in Appendix II. We have paid careful attention to what we were told and would like to thank the various individuals and organisations concerned. Some produced reports which were remarkable for their careful preparation and their analysis in depth of problems: we felt that they were partners in our efforts as well as witnesses. As for our own research activities, some of them of a pioneering kind, we would like to thank the Office of Population Censuses and Surveys and Social and Community Planning Research for the work they carried out so efficiently on our behalf and, among many others, the United Kingdom Council for Overseas Student Affairs and Political and Economic Planning for making the results of their current research available to us. We have described in more detail the nature of the research referred to in Appendix I. We hope the Departments will make any unpublished results of research carried out on our behalf available to interested parties on request. We recognise, of course, that the success of these research ventures depended not only on the quality of the researchers but on the cooperation of hospitals, local health authorities and members of the nursing and midwifery professions and we were greatly encouraged by the extent of that cooperation both when pilot schemes were being put forward and when final schemes were being implemented.

Finally, but not least, we wish to thank our able and industrious Secretary, Miss Elisabeth Singleton, who has given unstinted service to the Committee throughout its life and to the other members of the secretarial team, particularly Mr. Clive Bailey, Miss Margaret Brabant, Mr. Raymond Cubitt, Mr. Mark Ison, Mr. Alan Miley, Mr. Brian Peskett and Mr. Neville Teller, all of whom were secretaries to one or more of our Sub-Committees or Working Groups. Miss Singleton's task has never been an easy one and she has played an invaluable part in ensuring the continuity and coordination of all the different branches of our work. I would like to add my personal thanks as Chairman of the Committee to her and to her team. Without their efforts, not least in the final stages, we would never have been able to complete our report by the summer of 1972.

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CHAPTER I

URGENT PROBLEMS: LONG-TERM TRENDS

THE BACKGROUND TO THE WORK OF THE COMMITTEE

1. There have been many committees on nursing and midwifery in this country during the course of the last forty years, and many reports, official and unofficial, have been published. Our Committee was set up in June 1970 with the following terms of reference:

“to review the role of the nurse and the midwife in the hospital and the community and the education and training required for that role, so that the best use is made of available manpower to meet present needs and the needs of an integrated health service.”

2. It is the last phrase in this remit which distinguishes our enquiry from that of our predecessors. When we were appointed, there was widespread agreement on the need to replace fragmented health services by an integrated structure of health care, concerned with prevention as well as with cure. At the same time, no decision had yet been made upon the organisational framework within which policies designed to achieve integration were to be pursued.

3. Since nurses and midwives constitute the largest group of National Health Service staff¹, the success of integration policies will depend substantially on their effective education and deployment. Likewise, it is impossible to define nursing objectives, to identify nursing resources, to assess present nursing performance and to forecast future nursing requirements without taking full account of the moves towards integration within the National Health Service as a whole.

4. Given these perspectives, we found it necessary from the beginning of our enquiries to seek to identify short-term and long-term problems and opportunities and to clarify the relationship between the short-term and the long-term. Concern about short-term tendencies was deep-seated. Yet we noted that during the decade before we were appointed, the decade from 1959–60 to 1969–70, total spending on the salaries of hospital nurses and midwives, including nursing auxiliaries and assistants, had risen in England and Wales by 127 per cent and in Scotland by 133 per cent. In England and Wales this spending had grown as a proportion of total current spending on the hospital service from 24·2 per cent to 26·7 per cent. In Scotland the proportion remained higher than in England and Wales, but had fallen from 29·3 per cent to twenty-eight per cent. Meanwhile over the same period total spending on all aspects of community nursing and midwifery services had risen in England and Wales by 115 per cent. In terms of manpower, the increase in whole-time equivalent nursing and midwifery staff employed in National Health Service hospitals had risen by approximately thirty-one per cent. More detailed information is given in Chapter V.

¹ Details of the composition of the staff are set out below in Chapter V, paragraph 401.

5. Total nursing and midwifery numbers grew during the 1960s and have reached new heights each year. Even given the reduction in the length of the working week which took place during this period, total working hours available increased. And this increase was achieved in a period when the total labour force was contracting. The proportion of hospital nurses and midwives in the total working population of Great Britain rose from 1.1 per cent in 1964 to 1.3 per cent in 1970 and female hospital nurses and midwives as a proportion of the female working population rose from 2.7 per cent in 1964 to 3.3 per cent in 1970. Despite a fall in the number of eighteen-year-olds after 1965, the number of nurses in training as a proportion of the age group has increased substantially: not all, of course, are drawn from that age group, as we show in Chapter III, paragraph 191.

6. The rise in expenditures and in numbers, which set the terms of the short-term situation and provided the subject of much immediate comment, was obviously a matter for us to study in detail. So, too, if we were to deal with the wide range of questions relating to "the best use of available manpower", was the prevalent concern about "shortages" and "wastage" rates.

7. We clearly had to concern ourselves, however, with opinions and attitudes as well as with "hard facts". Just when the conception of an integrated National Health Service unifying hospital and community services was beginning to take shape, doubts were being widely expressed as to whether the nursing and midwifery staffing needs of a developing service could be met during the first critical decade of change. More profound doubts were being expressed also about the adequacy and suitability within this context of nurse and midwife education and training upon which the future of the profession was rightly felt to rest. In this connection we noted the sombre words at the beginning of the annual report¹ of the Royal College of Nursing for 1971 that "all is not well with nursing".

8. Throughout the course of our enquiries, we have remained aware of a strong sense of urgency, most strongly expressed by nurses and midwives themselves, behind the view that the whole professional scene in nursing and midwifery should be surveyed and new policies appropriate for a changing National Health Service should be devised and implemented. "It is the considered opinion of the Association", we were told, for example, by the Association of Nurse Administrators, "that the time is overdue for a radical review of the nursing situation."

9. In order to define objectives and to chart policies we had to clear the ground through research. The details of our research programme are discussed more fully in Appendix I. Part of this research, related to nursing and midwifery resources and their most effective use, is the subject of Chapter V of our Report: another part is related to opinions and attitudes. We collected material of this second variety—and it is used in all chapters of our Report—from specially commissioned surveys, including a postal survey of the opinions of nurses and midwives based on a random sample both of hospital and community staff (including auxiliaries and assistants as well as professionally qualified nurses and midwives) and an interview survey in depth of the opinions of a smaller sub-sample.

10. This material we set alongside the written and oral evidence submitted to us both from individuals and from organisations directly or indirectly concerned

¹ See list of references, no. 105.

with nursing and midwifery. We also took full account of the impressions we formed on a series of visits to hospitals and community health services. On these occasions we were able to talk freely and constructively, usually informally, with qualified nurses and midwives of all grades, nurses and midwives in training (the group on whom the long-term future depends) and auxiliaries and assistants. We also met doctors and administrators and members of most other National Health Service groups, including boards and management committees, who will be involved in the moves towards integration.

ATTITUDES OF NURSES AND MIDWIVES TOWARDS INTEGRATION

11. We noted that nurses and midwives themselves recognise the need for integration in the interests of patient care. All the recommendations we make in this Report are related to this basic concept of patient care, care in many different types of situation, including preventive care and general and specialist care at different times and for different people with low and high degrees of dependency.

12. As integration proceeds in the National Health Service, it must be possible to secure both greater continuity of care of individual patients and more flexible and cooperative deployment of nursing and midwifery staff. This will mean planning nursing and midwifery requirements across the current dividing lines of hospital and community. There will be a long-term trend to concentrate use of hospital facilities (including equipment and skills) for acute care, to provide in-patient accommodation only when essential, and to link out-patient, day patient, and diagnostic facilities with an expanding domiciliary service in which group practices in or outside health centres will play a major role.

13. We are in full agreement with the statement made to us in two parts by the General Nursing Council for England and Wales—first, that “the role of the nurse must always be closely related to the needs of the patients” and, second, that “these needs are never static, but vary according to individual patients, medical and technical advances, and developments such as the possibility of a unified nursing service. Thus, the role of the nurse is continually changing”. We would add that this changing role can never be considered adequately in isolation from the role of other members of the National Health Service.

14. When we asked hospital and community nurses and midwives their opinion on the statement, “Hospital nurses and local authority nurses do not work closely enough together”, both groups agreed with the statement, the community nurses and midwives more strongly than the hospital nurses and midwives.

TABLE 1
EXTENT OF AGREEMENT WITH PROPOSITION THAT “HOSPITAL
NURSES AND LOCAL AUTHORITY NURSES DO NOT WORK CLOSELY
ENOUGH TOGETHER”

	<i>Hospital nurses and midwives</i> %	<i>Local authority nurses and midwives</i> %
Agree strongly	18	39
Agree	52	50
Disagree	17	9
Disagree strongly	2	1
NK*	11	1

* Not known.

Source: Postal Survey.

15. Community nurses and midwives were also asked to say how much they agreed or disagreed with the two statements “Many of the people who are being treated in hospital at the moment should really be looked after by the local authority nursing service” and “Many of the people who are being cared for by the local authority nursing service should really go into hospital”. The two statements are not necessarily complementary, but for a nurse or midwife to agree with both would imply a belief that the present system is seen as ineffective or inconsistent. In fact fifty-seven per cent of community nurses and midwives agreed with the first statement and sixty-five per cent of community nurses and midwives with the second.

16. It is not only opinions which are changing. The pattern of community provision is already being transformed at the base with the growth of schemes of group attachment, and there has been a marked increase in the numbers of community nurses (i.e., health visitors and home nurses) and midwives attached to general practice. About two-thirds of all local authorities in England and Wales have now introduced schemes of group attachment. The growth in the proportions of total community nursing staff attached to general practice is set out in the following table:

TABLE 2

NUMBERS OF COMMUNITY NURSES ATTACHED TO GENERAL PRACTICE IN 1969, 1970 AND 1971 (ENGLAND AND WALES)

	<i>Numbers of staff working wholly and partly within attachment schemes*</i>		
	1969†	1970†	1971‡
Health visitors	3154	4010	4736
Home nurses (a) SRN	3192	4644	5428
(b) SEN	482	692	901
Combined health visitor-home nurse duties	420	406	445

Source: DHSS and WO.

* Full attachment schemes are those in which a health visitor or home nurse is responsible for providing local health authority services to all patients on the lists of specified general practitioners with whom she has regular consultations.

† Figures for 31 October.

‡ Figures for 30 September.

Such attachment brings nurses and midwives through medical practices into closer and continuing relationships with individuals and families, in both clinical and home settings.

17. Likewise, the number of health centres has grown dramatically. Between 1964 and 1971 the number of health centres in England and Wales had grown from twenty-one to 307, with 138 more being built, a further eighty-eight approved and 148 being actively planned. Similarly, the number of health centres in Scotland has risen from two in 1964 to thirty-four already built, thirteen under construction, twenty-seven approved and eight being actively planned.

18. In recent years, following the publication of *A Hospital Plan for England and Wales*¹ (Cmd. 1604, 1962) there has been an acceleration of the hospital building programme. Developments of hospital design and function have been introduced which have influenced the work of nurses and midwives and the way in which it is organised. Studies so far carried out indicate that the design of hospital facilities has less effect on the numbers of nurses and midwives required than one might expect. At the same time, insofar as the planning and designing of new hospitals have entailed a careful examination of their function, the range of facilities they offer and the balance between treatment and care in hospital and treatment and care in the community, a stimulus has been given to the kind of thinking relevant to integration. The planning of the “best buy” hospitals,² for example, has been carried out with and in anticipation of the closest possible cooperation between hospital and community services.

19. The emphasis is currently placed—and to an increasing extent—first, on treating patients whenever possible without admission to hospital and second, on discharging them from hospital as soon as reasonably possible consistent with their safety. This approach has very definite implications for nursing and midwifery. It means that within hospitals the pace, pressure and intensity of work have stepped up because a greater proportion of the patients are in need of active treatment. It has also meant that the quantity and nature of the burden carried by the community nursing services has altered markedly. The fact that greater emphasis is being placed on more highly dependent patients in the work of the community health services has resulted in a widening of the specialist skills required by nurses in the community, as well as a growing need for more nurses. The development of specialised units has also made demands on nursing both qualitatively, since new technical skills have had to be acquired and quantitatively, since most of the new forms of surgical and medical treatment require generous staffing.

20. In the longer run, as the report³ of the Central Health Services Council on *The Functions of the District General Hospital* (1969) has put it, the essential function of the hospital within an integrated National Health Service will be to provide “those medical, para-medical and nursing services which, either because of the specialised skills and equipment or because of the degree of care required, cannot economically be provided in the patient’s own home or at the health/group practice centres in the community”. A number of questions are still not finally resolved; in particular, the size of district general hospitals and the degree of concentration of facilities in them and the scale of provision and exact role of community hospitals to be developed in support of the district general hospital. Nevertheless, there is clearly an intended shift of emphasis to treatment in the community and a realisation of the interdependence of hospital and community health services which is the main factor underlying the proposed integration of the National Health Service.

21. We note that over the past decade the community nursing services, despite a decline in domiciliary confinements and the consequent reduction in the

¹ See list of references, no. 75.

² See Glossary.

³ See list of references, no. 13.

numbers of domiciliary midwives employed, have increased their total nursing staff at broadly the same rate as the hospital service. To some extent this has been due to a considerable increase in the numbers of home nurses and health visitors employed. This is a creditable achievement in view of the heavy competing pressures on the limited resources of local authorities, but growth should in the future be even greater if current policies are to be implemented successfully. The integration of the National Health Service will for the first time place on a single authority within a given area the opportunity and the duty to assess priorities of development across the whole health field. If the change in emphasis to community care is to be achieved, attention must be paid from the start to determining the number of community nurses required over a period of planned growth, to the potential supply and to their range of duties, including preventive duties with an educational dimension. Nurse and midwives working in the community must be so educated themselves and so deployed that they can accept responsibility along with family doctors in the provision of a whole span of preventive, caring and after-care services for individuals and families.

22. We believe that as society becomes interested in health as distinct from disease there will no longer be any basis for duality between hospital and community within the profession. Community services which once were provided to fill in gaps where there were inadequacies in health provision through general practice or hospital services will become integrated services. Group practices within or outside health centres and an extending range of specialised units and agencies will form part of the new pattern. It will be essential not only that there shall be adequate communication and effective planning of resources, including nursing and midwifery resources, between hospital and community teams, but that ultimately both hospital and community teams will be directly related to each other and planned within the same system.

23. Much of what is said above applies equally to nursing and midwifery. In midwifery, as in nursing, the importance of preventive health has been increasingly recognised, and midwives have had to respond to new medical and scientific advances in, for instance, neonatology, the understanding and care of new-born children. There are, however, important special considerations where midwifery is concerned. Midwifery has historically been a separate profession from nursing. Despite the fact that in England and Wales approximately ninety-five per cent of pupil midwives and eighty-five per cent of midwives stating their intention to practise over the last two years were registered or enrolled nurses—the figures for Scotland are one hundred per cent—statutory control of midwifery education and professional standards has a different history and a different scope from that for nursing. We deal in more detail with the implications of this separatism in later chapters of our Report.

24. During recent years there have been several significant changes in midwifery practice, and we have taken note of the relatively advanced stage of hospital and community integration already reached. Since 1955 the hospital confinement rate in Great Britain has risen steadily from fifty-five per cent to eighty-seven per cent of births in 1970 and the average duration of stay has dropped from ten to 6.1 days, with an increase in planned early discharge after forty-eight hours. The trend has been most marked in Scotland, where the hospital confinement rate

was ninety-five per cent in 1970. These developments have completely changed the balance of maternity work between hospital and community.

25. While fears have sometimes been expressed that the midwife's role, wherever she works, is in danger of being impoverished, successful two-way traffic between hospital and domiciliary maternity services has been developed. In some areas, this has brought with it involvement of hospital as well as community midwives in ante-natal and post-natal care in the community and, in others, the attendance of domiciliary midwives at hospital confinements through, for instance, general practitioner units. This process, which was already happening naturally, has been hastened following the report¹ of the sub-committee of the Standing Maternity and Midwifery Advisory Committee under Sir John Peel (1970) which recommended the unification of the maternity services in England and Wales and the replacement of small isolated obstetric units by larger consultant and general practitioner units in general hospitals with shared facilities.

26. We support these recommendations, and throughout our Report have considered the role of the midwife within the context of an integrated National Health Service. Indeed, we believe the integration which is already occurring in the midwifery services should be encouraged and planned for in the nursing services generally.

INTEGRATION AND CARE

27. Moves towards integration of the National Health Service are obviously induced by both central and local economic pressures to use resources effectively, including nursing and midwifery resources. They can also be inspired, however, by a deeper concern for the continuity of patient care. Each new generation brings new problems and new expectations. In time, the public will come to expect a network of services starting with services based on group medical practice within or outside health centres. All nurses and midwives will be expected to play a greater part in educating the family as well as the individual, in preventive health, including family planning, as well as in remedial care.

28. We have tried throughout this Report to assess nursing and midwifery needs in the light of the needs of individuals and families, given the fact that for significant parts of their lives, varying in their duration, the individuals must be considered as "patients", with different degrees of dependency and making different calls on specialised services. If preventive health is at one end of the spectrum of nursing needs, disabling chronic illness, endured at home, is at the other.

29. While attitudes to health and disease are changing along with social aspirations, the incidence of disease in the modern community is changing too, and this second change will influence the calls made upon nurses and midwives. In trying to look at future nursing and midwifery needs we note a number of recent trends:

¹ See list of references, no. 11.

- (a) a decrease in perinatal, neonatal and maternal mortality rates;
- (b) changes in official and public attitudes to abortion with direct health service consequences: in 1969 there were 36,630 abortions in National Health Service hospitals in Great Britain and in 1970, 51,317;
- (c) earlier identification of physical or mental handicap among young children;
- (d) a decrease in the number of children in hospital, but an increase in the intensity of nursing work because of more rapid turnover: moreover, a greater proportion of children are under five;
- (e) an increase in the incidence of sexually transmitted diseases: in the ten years from 1961 to 1971 the total number of new cases treated in Great Britain rose from 152,861 to 328,336;
- (f) socio-medical problem areas like drug addiction: the officially reported numbers of addicts to narcotic drugs in the United Kingdom increased from 437 in 1960 to 2,661 in 1970. In 1970 the numbers of hospital admissions due to the adverse effects of medicinal agents (including deliberate overdoses) were 79,160 in England and Wales and 7,270 in Scotland. In England and Wales 8,708 patients were also admitted to hospital in 1970 for treatment of alcoholism or alcoholic psychosis; the equivalent figure for Scotland was 3,180;
- (g) more accident and emergency work: between 1965 and 1970 the number of attendances¹ rose by five per cent in England and Wales and thirteen per cent in Scotland. These figures reflect the increased incidence of accidents, in particular motor vehicle accidents, but may also reflect changes in the availability of general practitioner services;
- (h) a decline in the incidence of infectious diseases;
- (i) a greater incidence of degenerative disease, particularly cardiovascular disease and its complications, also of cancer of the lung, and of diabetes;
- (j) a slight increase in the number of physically and/or mentally handicapped patients, including a number of seriously disabled patients, who in previous ages would not have lived. Here again the trend is away from full-time residence in hospital;
- (k) an increase in the numbers of people treated as mentally ill: in Great Britain between 1965 and 1970 the total number of day patient attendances increased by eighty per cent and total out-patient attendances increased by thirteen per cent, though in contrast, the average daily occupied beds fell by twelve per cent. People suffering from mental illness and under the care of the local authority services in Great Britain have increased by twenty-six per cent between 1965 and 1969, whilst those attending training centres have increased by eighty-seven per cent during the same period;
- (l) an increase in the numbers of elderly people in the population requiring preventive and clinical community nursing services: for example, between 1965 and 1970 the numbers of persons over sixty-five attended by health visitors and district nurses in Great Britain rose by forty-eight and twenty-eight per cent respectively;
- (m) an increase due to the prolongation of human life in the numbers of patients under the care of consultant geriatricians: in England and Wales

¹ Accident and emergency attendances are those of patients who arrive at a hospital unannounced and are seen and treated otherwise than at a consultative session.

in 1970 ten per cent of all hospital beds were occupied by such patients as compared with six per cent in 1965. In Wales alone and Scotland over the same period the figures were eight and six per cent and thirteen and eleven per cent respectively.

30. In drawing attention to the trends listed here we recognise that statistics provide no indication of the current extent or nature of unmet needs. If existing known needs were to be met, there would have to be a great increase in available nursing resources. If attempts were made to supply further nursing services, there would inevitably be difficult problems of priority.

31. Many of the recent trends have been the subject of official enquiry, and in some cases, at least, there is continuing debate about the most effective organisation of the National Health Service to meet such identifiable needs. We note, for example, the memorandum¹ *Hospital Services for the Mentally Ill* (December, 1971), produced by the Department of Health and Social Security and Welsh Office, which argues the case for a comprehensive service for the mentally ill, "in which the emphasis is on rehabilitation, on the preservation of continuity of the patient's personal relationships and of his contacts with the local community". Alongside hospital development, including geriatric departments, the provision of adequate community services is rightly deemed indispensable. Hospital and community nurses, along with social workers, it is suggested, have an important part to play in the care of mental illness before and after "patients" go into hospital or in cases where they do not go into hospital at all. The joint planning of systems of services, therefore, is indispensable.

32. In our view it is not the place of treatment that should determine the nurse's contribution, but the needs of the patient. Yet we recognise that, however beneficial to patients the changes proposed in the memorandum may be, they are bound to cause concern among those who have served patients faithfully for so long, often in the most difficult conditions, and to whom the future may now seem obscure. We believe that it is necessary to emphasise that as an integrated service takes shape, the range of opportunities open to nurses specialising in the care of the mentally ill will expand and not diminish. The setting in which care is delivered will change and the techniques of care will alter as knowledge grows, but the need for care and for nurses educated to provide that care can never disappear.

33. Plans for dealing with the mentally handicapped are still evolving and the issues arising out of the care of 120,000 severely mentally handicapped people, including 50,000 children, in England and Wales were recently explored in Cmnd. 4683 *Better Services for the Mentally Handicapped*² (1971) where a number of important recommendations are made. In the long run, most children may be based at home and many adults in hostels, going into hospitals for assessment or for intensive therapy. Smaller hospitals for the mentally handicapped may be developed closer to the community, and acute physical or psychiatric treatment may usually be given in hospitals dealing with these specialties. In Chapter VI of our Report we make a number of recommendations of our own about nursing care for the mentally handicapped, which raise basic questions concerning the relationship between nursing and social work.

¹ See list of references, no. 34.

² See list of references, no. 32.

34. We have referred briefly in paragraph 30(d) to changes in the intensity of work associated with the care of children in hospital. We note in this context the Departmental advice given to hospital authorities in HM(71)22¹ and earlier memoranda, advice which is leading to action. Two of the principles outlined in HM(71)22 are central to the theme of our Report—the need for better communications between hospital services which have traditionally been separate from each other and for better communications between hospitals and local health services. Another objective set out in the memorandum is that specialist training and refresher courses concerning the care of children should be available to staff working in children's units: this objective is in line with our own recommendations on refresher and post-Registration training.

35. Because the social dimensions of nursing and midwifery, both in the community and in the hospital, are so important in a period of rapid social change, we believe that all nurses and midwives must be aware of the “normal” as well as the “abnormal”, of the social repercussions of illness in different situations, of the interaction of patient and family and of hospital and community, and of the role of other colleagues in the caring professions, including social workers. We note the division of responsibility between “health services” and “social services” following the Local Authority Social Services Act² of 1970 and the Social Work (Scotland) Act³ 1968, but find it necessary to emphasise that the needs of individuals and families are not fragmented in this way. As far as nurses and midwives and social workers are concerned, we prefer to think in terms of links and of partnerships rather than of boundaries and potential conflicts and we return in more detail to this range of questions (including the provision of home helps) in Chapter II.

36. It is not only social change or changing patterns of disease and distress which influence nursing and midwifery care in practice but changes in medical knowledge and performance. This element in the situation must never be overlooked. We have noted among such changes in medical knowledge and performance, which should be considered alongside the changes set out in paragraph 29, to which they are a response or of which they may sometimes be a cause:

- (a) earlier identification of the handicapped;
- (b) the introduction of life-saving procedures—in some cases involving complex apparatus and protracted dependence of patients on both medical and nursing care;
- (c) the increasing technical content of medical work, including the emergence of new and sophisticated techniques in surgery, some employing ancillary specialists;
- (d) developments in the use of drugs and the science underlying their use including their use in anaesthesia;
- (e) changes in the approach of doctors to the diagnosis and treatment of mental illness;
- (f) research into the ageing process and its physical and psychological consequences, including terminal illness.

¹ See list of references, no. 33.

² See list of references, no. 62.

³ See list of references, no. 114.

37. This list will change with the advancement of knowledge, and as it changes the relationship between doctors and nurses will change also. Nonetheless, whatever the changes, doctors and nurses will be partners in patient care, and the terms of their partnership need to be stated explicitly. We have tried to do this in Chapter II of our Report.

NURSING AND MIDWIFERY AS THE MAJOR CARING PROFESSION

38. Within a changing social and medical context, nursing and midwifery, we believe, will continue to stand out as the major caring profession, certainly the one most in the mind of the public. The caring professions as a whole need to show kindness as well as intelligence and sympathy as well as skill. They will become more rather than less significant to people as society becomes more complex, and the claims they will make on resources must be viewed in this light.

39. Moreover, with an integrated National Health Service, the public will judge "caring" in terms of the quality of care given to them and their families as individuals, not as administrators would tend to judge it, in more general terms, as one necessary attribute of a health system. Since the provision of nursing and midwifery services must be directly related to the needs of the patient, nursing and midwifery should not be considered, as they so often are, simply as a series of jobs to be done, but rather as a series of roles to be discharged. It is necessary to point to the unique caring roles of nurses and midwives and to the dependence of society upon them. To do this it is essential to examine fundamentals.

40. Most nursing in society is carried out within the family by non-professionals—by relatives and friends. This has always been the case. Yet such care must by its nature be limited and will in large numbers of cases be quite inadequate. Patients and their families need additional help, often highly specialised help, in complex situations, in order to understand both illness and treatment. Thereby nurses and midwives can alleviate pressing practical worries, avoid recurrence if possible, and either ease convalescence and rehabilitation or see the patient move towards a peaceful and compassionate death. Nursing and midwifery support in the family setting must be related directly to nursing and midwifery support provided elsewhere.

41. Professional nursing and midwifery—that is to say nursing and midwifery for which individuals are selected, educated, managerially deployed and paid—has as its objectives continuity and coordination of care in the interests of the comfort, recovery and integrity of the person being cared for. Nurses and midwives are closer, as a team, to patients than any other group of National Health Service staff, and by virtue of this special relationship the comprehensive and continuous oversight of care is a central nursing and midwifery role and the ensuring of the right services to the patient at the right time, the special responsibility of the nurse or midwife. To carry out this basic integrating function (outside, inside and after discharge from hospital) involves a sensitive understanding of all the person's needs, physical, psychological and social. However "difficult" his case may be, the patient (and his family) must feel confidence that the care he is receiving is both skilled and responsible. The prescription of an appropriate social context for treatment is a major nursing skill which makes practical competence in social psychology no less important than expertise in aseptic techniques. It involves

other skills, too, not least in observation and assessment, not all of which can be sought in one individual. It also involves the taking of responsibility, often onerous and challenging responsibility.

42. There are four corollaries of this approach to nursing and midwifery. First, the conception of continuity and coordination in nursing and midwifery care presupposes teamwork and team leadership. Given the fact that the facilities of the community and of the hospital are complementary, nurses and midwives must work closely together in teams both within hospital and community and between them. We have tried later in our Report, therefore, to specify the necessary elements in a nursing or midwifery team. We wish to make it clear at the outset that without teamwork the objectives of this Report cannot be achieved.

43. Second, the term "team" can and should also be used in a wider sense with reference to "health teams" including doctors, nurses, midwives, technicians, administrators and others concerned with preventive, remedial and rehabilitative care. Within this bigger team the distinctive roles of the nurse and midwife must be fully recognised.

44. Third, the range of human and technical skills required in nursing and midwifery is very wide. Not one type of nurse is required, but many. Outstanding abilities and skills are necessary at one end of the range, whether the skills are applied in direct clinical care, in teaching or in management. We believe that the work of senior nurses and midwives who deal with complex problems of administration and policy making will benefit from the fact that they began their careers by providing direct personal care themselves.

45. Fourth, just as the family needs support in health care from professional nurses and midwives, so professional nurses and midwives require other kinds of support themselves if they are to discharge their distinctive roles most effectively. Later in our Report we have tried to identify such kinds of support, directing particular attention to the need for providing induction training for the large and growing numbers of nursing assistants and auxiliaries, nursing aides as we call them, on whom the profession depends. They are sometimes included in the same sets of statistics as professional nurses and midwives and their own role and functions left blurred. To us they appear to be indispensable members of health teams, but their place in those teams should be to support professional nurses and midwives. Some of them can and should go on to train to become professional nurses and midwives themselves.

46. Given the needs of the patient and the distinctive responsibilities of the professional nurse and midwife, it is of utmost importance that professional nurses and midwives in sufficient numbers are (a) properly educated to discharge their responsibilities, (b) offered attractive and easily identifiable career prospects, (c) efficiently deployed as individuals in relation both to their aptitudes and to the needs of patients, and (d) efficiently organised in teams and related organisationally to other groups of staff inside and outside the National Health Service.

EDUCATION AND NURSING CARE

47. We have devoted most of our attention in this Report to these four imperatives. All our other proposals presuppose a radical revision in the educa-

tional preparation of nurses and midwives to meet their wide and deep responsibilities for continuing care:

- (a) greater emphasis must be placed on *all* nurses and midwives being given a basic nursing education which will concentrate on the essentials of patient care;
- (b) such basic care involves the capacity to see the patient as a whole person, in relation to his family and society;
- (c) in their basic training nursing and midwifery students should be given proper preparation for working in teams;
- (d) education should develop the nurse's gift of adapting easily through various stages of training and experience to nursing patients in different conditions;
- (e) on the foundation of basic nursing education, further education must be provided for the different branches of specialist nursing and midwifery, some of them requiring rare attributes and abilities;
- (f) an element of continuing education must be built into the system;
- (g) career development must be related at every stage to the standard of professional knowledge and the relevant experience which has been attained. Each new step in career development must be dependent on the nurse or midwife attaining through experience and through education the professional knowledge and skills which are currently required for the kind of work to be undertaken;
- (h) given this approach, the dual system of entry into the nursing profession should disappear and there should be no distinction at the point of entry, as there is at present, between student nurses hoping to proceed to registration and pupil nurses hoping to become enrolled nurses.¹

48. In Chapter IV of this Report we outline a new educational system designed to meet the needs of the public and of the profession. We note at the outset, however, that changes are taking place in the national educational system which are as far-reaching as the changes in the National Health Service. Some of them indeed, derive from the same social aspirations and pressures. In particular, we direct attention to:

- (a) the increase in the numbers of boys and girls leaving school with O levels and A levels or their equivalent;
- (b) the increase in the numbers of students in institutions of higher education as a proportion of the age group;
- (c) the emergence of new institutions of higher education, including the polytechnics, some of which are concerned directly with professional education;
- (d) the recent reassessment, still incomplete, of the role of colleges of education;
- (e) the great expansion of facilities for further education, including professional education;
- (f) the creation of the Open University operating on a national basis;
- (g) clusters of qualitative changes throughout the educational system involving new curricular combinations and new methods of teaching;

¹ There are four parts of the register of nurses, each conferring a separate qualification; in general, sick children's, mental and mental subnormality (in Scotland mental deficiency) nursing. In Scotland, there is only one roll of nurses, but in England and Wales the roll has three parts, each conferring a separate qualification; in general, mental and mental subnormality nursing.

- (h) the increased measure of independence offered to students, particularly within the higher educational system, coupled with increased care and resources devoted to their individual counselling, the provision of social amenities for them and the encouragement of a greater degree of active participation in the affairs of the institutions of which they are members.

49. We do not recommend that nursing and midwifery education should fall within the ambit of the Department of Education and Science or that all nursing and midwifery students should be integrated into the higher educational system. We give reasons for our decision in Chapter VII. We emphasise, however, that there is scope for an expansion of education for nurses and midwives within institutions of higher education (including universities). We believe that both in the planning and operation of preparatory courses and continuing education within the profession there must be the closest cooperation between those involved in the provision of nursing and midwifery education and those working in other branches of education. We urge, too, that wherever possible there should be more active association of nursing and midwifery students with other students both in academic and in social activities.

50. The educational changes we are proposing should, in our view, be introduced as quickly as possible. To delay now would be to miss the right moment for action, when the integration of the National Health Service is proceeding, when the need for adaptation is urgent and when there is widespread interest in educational change. To achieve change, however, speedy action must be taken forthwith to provide an adequate supply of nurse and midwife teachers, and we explain in Chapter IV how necessary this provision is if the objectives of our Report are to be achieved.

51. The full effects of educational change will take some time to show, and since these long-term effects will have to be considered within the context of the developing National Health Service, they may be difficult to disentangle from the effects of other kinds of change. For this reason alone we suggest that the new educational system should regularly and systematically be subject to assessment and review. We regard it as essential that both educational and other policies in nursing and midwifery should be thought of as parts of a strategy within the overall context of National Health Service policy as a whole, not as piecemeal expedients. They should be feasible in terms of implementation, that is to say that those responsible for the strategy should not ignore demographic, educational or social factors outside the control of the National Health Service administration.

MANAGEMENT AND CARE

52. There has been far more appreciation in the past of the need to develop new patterns of education to secure the future quality of nursing care than there has been of the need to improve nursing management. We believe, therefore, that in the case of management, as of education, it is necessary to be clear about crucial relationships. We are in full agreement with a passage in *The Proper Study of the Nurse*¹, the first paper by Miss J. McFarlane in a series on *The Study of Nursing Care* initiated by the Royal College of Nursing, which reads: “the unique function

¹ See list of references, no. 70.

of the nurse is to give nursing care. To this function both nursing management and nursing education are in a service relationship. Their excellence can only be judged by the excellence of nursing care which they enable”.

53. In view of the emphasis we place in this Report on the importance of good management, it may be helpful to make clear exactly what we have in mind by that term. We consider that the purpose of management is to provide clear objectives on the one hand, and the means for meeting them on the other. It should ensure that the working conditions of nurses and midwives and their accommodation are such that they can make the best possible contribution to patient care and welfare. Senior nurses and midwives with delineated managerial responsibilities must assess, develop and improve standards of nursing or midwifery care in varying situations. We discuss these questions in greater depth in Chapters V and VI.

54. At present, there is still a good deal of “crisis management”, with those placed in key positions responding urgently and as best they can to day-to-day problems rather than planning far enough ahead. Nor is there enough recognition, amongst doctors as well as nurses and midwives, that good management starts within the health team itself. Just as every qualified nurse or midwife should be in some sense an educator, so every qualified nurse and midwife must be in some sense a manager.

55. Management and care are not, therefore, as is so often stated, conflicting conceptions. Rather, good management is a precondition of good care. To ensure that existing numbers of nurses and midwives are used to the best effect, and that any growth in the number of nurses and midwives during the next decade will be used to improve the quality of patient care, there will have to be rational and imaginative control of scarce nursing and midwifery resources in the interests of the patient. Given what we have said about the special role and responsibilities of nurses and midwives, we consider it essential that nurses and midwives themselves, with professional experience at their command, will be in a position at every level—beginning at the level of the clinical team—to explain first what the acceptable minimum of nursing or midwifery care is, second what in any given situation is the best pattern of care, and third how external restraints on money, manpower and physical resources will affect its provision.

56. We have been offered extremely valuable evidence by the National Nursing Staff Committee, set up in 1967, as well as by its Scottish counterpart. Both bodies are concerned with the direct effects of management training on the quality of patient care in hospitals. Among the points made to us by the NNSC, we note that half the one hundred thousand full and part-time registered hospital nurses in the National Health Service are ward sisters and upwards, and where they have been given the opportunity of following management courses they have often been able to tackle practical problems within their own experience and range of responsibilities with immediate and practical results, analysing situations, defining objectives, and assessing the results of change. In such circumstances there is nothing remote or contrived about the conception of management.

57. Courses in middle management and senior management have encouraged a new approach to such diverse and supremely practical questions as the work

load of midwifery staff in an ante-natal clinic, the standardisation of drug distribution and the changeover from a single-sex ward to a ward containing patients of both sexes. The collected reports we have received from the National Nursing Staff Committee demonstrate beyond doubt that good management can prevent “dehumanisation” and “depersonalisation”. By its nature it is not bureaucratic, but the reverse.

58. We have carried out our enquiries while the recommendations of the Salmon Committee on *Senior Nursing Staff Structure*¹ (1966) are in the course of active implementation in hospitals, while the proposals of the Mayston Report² (1969) on community nursing are beginning to influence the pattern of community health administration, and while the ideas in the two Cogwheel Reports^{3,4} (1967 and 1972) and the Brotherston Report⁵ (1971) on medical management in hospitals are beginning to influence working relationships between doctors and nurses. The most recent report⁶ (1972), that of the Hunter Committee, relates to medical administrators and is already affecting attitudes in this field.

59. The Salmon Report, which set out to raise nursing from “the secondary position which it seemed to occupy”, introduced a new structure in nursing and midwifery. The structure is headed by a Chief Nursing Officer, a new post, responsible direct to the governing body for all the nursing and midwifery services, including education, within a group of hospitals. The Chief Nursing Officer is supported by Principal Nursing Officers responsible for the management of a division of nursing, midwifery or nurse education, Senior Nursing Officers in control of areas, and Nursing Officers in control of units. Units comprise groups of wards and/or departments, e.g. theatres, providing the Nursing Officers with a combined managerial and clinical role.

60. In Chapter VI of our Report we discuss particular aspects of this structure and make a number of recommendations concerning new posts in clinical nursing and midwifery and in nursing and midwifery education. We have preferred throughout our Report to talk of duties and responsibilities rather than in terms of numbered Salmon grades and we have tried to extend recognition of clinical and educational duties and responsibilities as well as managerial duties and responsibilities. We are in full agreement with the Salmon Committee, however, in pressing for increased participation by nurses and midwives in decision making processes, and we welcome the genuine improvements which have been brought about in practice as the Salmon Report has been put into operation.

61. We are aware, of course, of the strains and stresses, individual and collective, which often accompany adaptation and reorganisation. Yet we do not believe that there can ever be a definitive phase when processes of adaptation and reorganisation are finally halted. There are bound to be future changes as the process of integration continues, and if these are to be carried through with the minimum strain and stress it is necessary that senior nurse and midwife managers, even more

¹ See list of references, no. 79.

² See list of references, no. 39.

³ See list of references, no. 78.

⁴ See list of references, no. 27.

⁵ See list of references, no. 108.

⁶ See list of references, no. 30.

than at present, must take part in the shared management of the resources of an integrated National Health Service. Their role must be based ultimately on a clear conception of objectives arising from regular reappraisal of clinical and other needs.

62. We have noted that it seems likely that by 1972/73 all hospital groups will have appointed a Chief Nursing Officer or, where appropriate, a Principal Nursing Officer and that many groups will also have appointed all their senior grades. These appointments carry great responsibilities, but they should not be thought of in bureaucratic terms. The Salmon structure is not a rigid and static organisation, but one which is flexible and capable of being adapted to meet the changing needs, to which we have already referred, of the services to be administered. It can and should accommodate the different styles of management of different individuals and should facilitate sensitive and sensible response to a great variety of different situations.

63. We also note the key role assigned to the Director of Nursing Services within the community health service administration by the Mayston Committee, and we would wish to stress with them the importance of full participation by nurses and midwives in family teams which will include members of different professions. Progress in the implementation of the Mayston Report has been substantial while we have been preparing our own Report.

TABLE 3

IMPLEMENTATION OF THE MAYSTON REPORT

	<i>Position as at 31.12.1970</i>	<i>Position as at 27.3.1972</i>	<i>Position as at 20.7.1972</i>
Total number of local health authorities (England)	158	158	158
Number of Directors of Nursing Services in post	107	124	132
Number of authorities who have made proposals	57	138	147
Formal or informal agreement given	4	105	125
Schemes fully implemented	—	27	51
Schemes partially implemented	—	34	42

Source: DHSS.

ORGANISATION, COMMUNICATIONS AND MORALE

64. We expect that during the next stage of reorganisation—that involving the integration of hospital and community services—a number of unanticipated organisational problems will arise. During such periods we believe that there should be experiment with new ideas and forms of organisation. There must be open communication about what is going on, and thorough evaluation of successes and failures.

65. It has sometimes been suggested that the far-reaching organisational changes of recent years have affected morale. In fact, we have found very little general evidence of low morale or of cynicism in the nursing and midwifery profession, although we recognise that both low morale and cynicism can be found

in particular situations. In general, our survey of opinions of nurses and midwives at present employed or in course of training revealed that a very high proportion of them, whatever the strains to which they are subjected, find great satisfaction in their profession. While it is common for people to express a fairly high level of satisfaction with the job which they are currently doing, since its positive appeal has more reality for them than that of alternative jobs, the figures we collected suggest an exceptional state of affairs. Only three per cent of the people questioned felt that there were other types of work which they would find more satisfying. Moreover only three per cent of the hospital nurses and midwives and one per cent of the community nurses and midwives we approached thought they would be working outside the profession in two years' time. Of qualified female nurses and midwives who had left the profession only twenty-five per cent said that they would be unlikely to return, and their reasons tended to be personal rather than associated with dissatisfaction with nursing or midwifery as such.

66. In later sections of our Report we examine deviations from this pattern along with some of the main indicators of grievances concerning conditions and hours of work and promotion prospects in nursing and midwifery. We note at this point, however, the responses to a number of statements which we put to nurses and midwives concerning some of the chief determinants of morale.

TABLE 4

EXTENT OF AGREEMENT WITH STATEMENTS OF OPINION CONCERNING
NURSES' MORALE, BY HOSPITAL AND COMMUNITY NURSES AND MIDWIVES,
AND SEX OF HOSPITAL NURSES

Statement of Opinion	Hospital nurses and midwives			All community nurses and midwives
	All	Male	Female	% Agreeing
	% Agreeing	% Agreeing	% Agreeing	
Not enough effort is made to find out what nurses think	79	80	78	72
Routine tends to be more important than the welfare of the patient	46	55	45	31
Not enough care is taken to keep nurses informed about what is going on	68	71	67	63
At night-time it is often difficult to get in touch with a senior person when a problem comes up	19	22	17	34
Even by day-time, it is often difficult to get in touch with a senior person when a problem comes up	11	20	10	33
Compared with registered nurses, enrolled nurses do not get enough credit for the work they do	56	55	56	40
Part-time nurses should take a fairer share of the difficult hours	70	80	69	65
Administration and training of nurses are less satisfying than direct patient care	56	51	57	51
A nurse's career can often be unfairly damaged by a "bad report"	76	80	76	NA*

* NA = Not Applicable.

Source: Postal Survey.

67. Over three-quarters of hospital nurses and midwives agreed (thirty-six per cent “strongly”) that “not enough effort is made to find out what nurses think”. Community nurses and midwives agreed with this opinion almost as strongly. Senior nurses and midwives from both fields were less likely to agree with the statement than other grades, but, nonetheless, over half agreed.

68. Almost as many nurses and midwives agreed that “not enough care is taken to keep nurses informed about what is going on” (sixty-eight per cent of hospital nurses and midwives, twenty-eight per cent of them “strongly”: sixty-three per cent of community nurses and midwives, twenty-six per cent of them “strongly”). The same pattern of differences by grade can also be observed.

69. Hospital nurses and midwives were also presented with the statement “senior nurses often forget what it was like to be a junior nurse”. Three-quarters of nurses and midwives agreed (thirty-six per cent “strongly”) and even among senior nurses sixty per cent (though only eleven per cent of them “strongly”). Almost all the students (eighty-nine per cent), pupils (ninety-two per cent) and enrolled nurses (eighty-four per cent) agreed: in the case of the trainees over half agreed strongly.

70. Those responses point to the importance of better and more thoughtful communications within the profession and of freer and wider ranging communication between nurses and midwives and others. Although the concept of autocratic hierarchy which has been so powerful in the modern history of nursing and midwifery is being challenged, not least by the implementation of the Salmon proposals, which in many important respects are designed to remedy the failings we recognise, it remains strong and pervasive. Archaic styles of leadership can create particular difficulties when the profession includes, as it does in hospitals, equally large groups of young nurses and midwives under twenty-five and nurses and midwives over forty-five. There is room for different approaches to group relationships, but it should be obvious that senior nurses and midwives should not issue reprimands in public, that ward sisters should discuss their reports with students and that all reports on individual nurses and midwives should be written with the greatest possible care. Careers advice is essential. We hope that in the light of our Report more attention will be paid throughout the profession to teamwork (which includes leadership of the right kind) instead of formal hierarchy and to function instead of to status.

PUBLIC IMAGES

71. There is a strong feeling outside the profession, which has been conveyed to us by many witnesses, that too many bewildering distinctions exist within nursing and midwifery—too many avenues of entry, too many courses in too many places of study, too many qualifications, too many grades, too many controlling or regulating bodies. We argue strongly that there should be an integrated statutory body for the profession, one common pattern of initial education and one intelligible career structure allowing for individual choice and mobility, the terms of which can be carefully spelt out, and for the advancement of individuals of proven ability and calibre to direct the future of the profession.

72. Given our stress in this Report on patient needs, we were anxious to collect the views, not only of nurses and midwives on patient care but those of officers and

spokesmen of voluntary bodies concerned with nursing and midwifery and of members of the general public on nursing and midwifery. We have been deeply impressed with the high regard expressed on all sides for the profession and the work that it carries out. We note, for example, that the King Edward's Hospital Fund for London report¹ of 1969 on *Patients and their Hospitals* stated that when hospital patients being interviewed were asked what they liked best in hospitals ninety-three per cent chose human and organisational factors, with "nurses" coming top of the list. Patients' attitudes have often prompted changes in patient care in the past, and the role of a more educated public in the creation of new attitudes should not be underestimated.

73. Nursing and midwifery are not generally thought to be professions of "inferior status". They continue to confer high status in the community as a whole as worthwhile and rewarding occupations. Yet nursing and midwifery pay (which, while it falls outside our terms of reference, rightly does not fall outside the terms of most people's thinking about the present and the future of nursing and midwifery) is thought to be low and conditions of work are thought to be less good than in many occupations of inferior status. In part these discrepancies are due to another common misconception; a lack of awareness of the wide variety of levels and kinds of nursing and midwifery work. The public is highly sensitive, through the media of communications, to the fairness or unfairness of the way individual nurses and midwives are treated in training and afterwards. Chapter II, which we deemed necessary to include in our Report, deals more fully with the "image" of nurses and midwives and with myths and realities, as we see them, in relation to nursing and midwifery as a profession.

74. While large numbers of people, often speaking from direct experience, regard nursing and midwifery as the caring profession about which they themselves care the most, there is a far less general recognition, even among relatively knowledgeable sections of the public, like the teaching profession, which should be in a position to know, of the immense variety within the nursing and midwifery profession. We hope that our Report will give the widest publicity not only to the problems of the profession in a changing society but to the widening variety of opportunities for individuals of very different kinds.

75. On "integration" itself we believe that there is need for greater public awareness of the new direction of National Health Service policies and the possible effects that integration will have on the quality and organisation of nursing and midwifery care.

RESOURCES AND OBJECTIVES

76. We have left to the end of this introductory chapter one of the main elements in our enquiry—the availability and deployment of nursing and midwifery resources. These subjects are discussed fully in Chapter V of our Report where we challenge the widely held view that all the problems of the nursing profession would be overcome if only there were more nurses and midwives. We recognise that there are shortages, some of them serious, in particular places and in particular sectors of the National Health Service as it is at present administered, and that

¹ See list of references, no. 101.

these require careful and urgent attention. Moreover, as integration proceeds we see more serious shortages looming large unless there are significant changes in manpower policies involving both improved information systems and new personnel policies.

77. In considering current misallocation and maldistribution and in planning for the integrated National Health Service of the future, it is essential to focus thought on and to relate policy to the demand for nurses and midwives as well as on the supply and on the balance between nurses and midwives and others. Demand factors will change as integration proceeds. We return, therefore, to the conception of "strategy" outlined in paragraph 51. Misallocation and maldistribution of nursing and midwifery resources can create just as difficult problems as actual shortages through failure to recruit or to retain. Strategic planning will require a new approach to manpower questions at the local, regional and national levels.

78. In relation to current staffing difficulties we note that such data as are available at national level are inadequate both in relation to the overall balance between demand and supply and in relation to local variations. We revert to this subject in greater detail in Chapter V, paragraph 406.

79. In Chapter V of our Report we deal with this range of questions in more depth and also widen the range, emphasising at this point that the trend towards a genuinely integrated National Health Service encompassing all hospital and community services and new forms of provision increases the need for a systematic approach in order to allot total resources available in terms of identified needs and for recommendations designed to strengthen such an approach. The recommendations follow in Chapter V.

THE SHAPE OF OUR REPORT

80. This Report, which is concerned with nursing objectives in an integrated National Health Service, is itself an integrated document, that is to say that the proposals made in separate chapters are all related to each other. This chapter provides an essential introduction. Chapter V, as has been explained, includes some of the basic facts and figures about nursing and midwifery resources which must be taken into account in policy planning: it is complementary to Chapter II which deals with attitudes and impressions. Chapter III is concerned with the pattern of nurse and midwife training as it is carried out at present and with some of the objections made to it: we have relied heavily in this chapter on the opinions we have collected in our surveys. Chapter IV sets out our recommendations about what we regard as the necessary educational pattern of the future on which the future of the profession will rest. Chapter VI deals with the structure of the profession and with the range of opportunities for the individuals inside it. We stress from the outset that patients' changing needs can be satisfied in the long run only if a structure for the nursing and midwifery profession exists which also serves and is thought to serve the profession well. It must be a structure which is attractive from the outside and satisfying from the inside. We recognise also that it is necessary to phase our proposals, and Chapter VII of our Report deals with institutional frameworks and time-tables of change. We have drawn attention to the need to allow for "transitional periods", when, pending the full implementation of new policies, it will be essential to safeguard the interests of the patients and of the

nurses and midwives at present in the National Health Service and we have also left some options open. We believe, however, that the general pattern we recommend is the one most suited both to improve short-term conditions and to facilitate longer-term policies designed to secure full integration. We recognise that unless the proposals we make in our final chapter are regarded as realistic—and we believe them to be completely realistic—the rest of our proposals will drift into the clouds.

CHAPTER II

NURSES, MIDWIVES AND THE PUBLIC: IMAGES AND REALITIES

INHERITED IMAGES AND THE MODERN NURSE AND MIDWIFE

81. "The public image of any trade or profession," we were told by the National Association of Head Teachers, "can influence considerably recruitment to that trade or profession." As is true of many other professions, nursing retains an inherited image which belongs to the late nineteenth century. "The lady with the lamp" or "the ministering angel" and similar visions linger in the mind. The familiar association of the nurse with pain, suffering and death and the tendency to place her (almost always "her" rather than "him") within the setting of a hospital impede an understanding of the great variety of jobs nurses actually do. The midwife has a quite different and contrasting image associated with the "happy events" within the family's own history. She seems to have little to do with the care of the sick, and she has her own recognised place in society. She may act on her own within limits which are carefully laid down. Nor are these the only two relevant images. In some parts of the country there is a surviving nineteenth-century image of the district nurse, and she, too, has a very real prestige of her own.

82. Even nurses themselves are influenced by images, and though there are often discrepancies between images and realities, some of the actual structures reinforce the images. With the moves towards integration new links have been forged between community and hospital nursing, yet great gaps remain. In the recent Queen's Institute survey¹ of enrolled nurses in the community only forty per cent of health visitors ("generalists" with a special interest in preventive care rather than specialists) said that they had any contact with hospital staff during the previous week. The figures for registered nurses were only twenty-two per cent and for enrolled nurses eleven per cent. "Nurses whose names appear on one part of the register," a professional nursing journal² commented while we were beginning work on our Report, "can hardly conduct a conversation with nurses whose names appear on a different part and any dialogue between them and a community nurse whose name appears on a different statutory register is often almost impossible". The article in which this passage appeared focused on the heterogeneity of the profession and was headed with Florence Nightingale's statement³ "I use the word nursing for the want of a better".

83. Florence Nightingale may have been uneasy about the terminology, but she had much to do with the creation of the inherited image. She did not create it alone, of course, nor was she responsible for all aspects of it. We have noted the following further features of the inherited image of the hospital nurse which seem to be determined by history:

- (a) it groups together doctors and nurses not as partners but as people in charge on the one hand and their "handmaidens" on the other. In the

¹ See list of references, no. 51.

² See list of references, no. 97.

³ See list of references, no. 86.

process of providing care the doctor needed a skilled helper, and in the inherited image (still treasured by some) the nurse figures as such—a person who is strictly ancillary;

- (b) at the same time, it is widely appreciated today that even this kind of historical grouping was not achieved without friction, that nurses had to fight, sometimes ruthlessly, for their status. The fact that the nurses were for the most part women and the doctors for the most part men was of the essence of the drama;
- (c) there has been a class element in the traditional picture. After Florence Nightingale enough nineteenth-century nurses from the higher social classes figure in the picture to provide a theme in itself—the theme of “vocation”, a theme, of course, with an older history leading back to the middle ages. The nurse was seen as living apart, thinking in terms not of money but of service, and evolving her own distinctive code. The adjective usually applied to her was “dedicated”;
- (d) the essence of the code—to use a phrase of the most recent historian of nursing, Brian Abel-Smith¹—was “the search for perfectionism and the attempt to achieve it by discipline”. The hierarchies were thought of as authoritarian, and the image of the matron remains today as one of the most powerful of all the popular nursing images.

84. When we started our enquiries in 1970, not all branches of the nursing profession were seen in terms of such inherited images and although there was inadequate recognition, as we have suggested, of the variety of jobs within the nursing profession, perhaps a larger cross-section of the community than ever before had some sense of the range.

85. In thinking of the future, it seemed important to us to clarify the relationship between present and past. We began, therefore, by listing some of the main groups of people with whom we were directly concerned in the early 1970s when we used the term “nurse”; they can be thought of within a framework both of work and grade:

- (a) in hospitals, which have their images as much as the people who work in them, we listed senior administrative and teaching staff in nursing and midwifery, Nursing Officers, ward sisters, midwifery sisters, staff midwives, staff nurses, senior enrolled nurses and enrolled nurses, unregistered students and post-registration students, midwives in training and pupil nurses. All these groups fall within the profession or intend to join it: the grades are very different from nineteenth-century grades, but there is a strong sense of status and some of the grades are distinguished by their uniforms;
- (b) we also identified nursing assistants and auxiliaries who have had no professional training. Patients may call them “nurse” and they enable service to the patient to be maintained and improved, not least at night, but they are outside the profession. They are unevenly distributed but their numbers have risen markedly in recent years;
- (c) in the community, functions are not always separated in the same formal way as they are in hospitals and there are overlapping combinations of duties between health visitors, district nurses and midwives. Yet we found

¹ See list of references, no. 1.

it necessary to distinguish between senior community nurses concerned with administration and teaching, health visitors, district nurses who may be either registered or enrolled, domiciliary midwives and a wide range of others, including school and clinic nurses. There are also ancillary staff supporting professional nurses in this field.

86. This is an extraordinarily wide spectrum, and we had to try to secure representatives from all parts of it when we embarked upon our opinion surveys. We also had to take note of a very wide range of local situations within which nurses and midwives work:

- (a) in the case of hospital services we found it necessary when we carried out our opinion surveys to consider hospitals not only by type but by size (below 250 beds, 251–1,000 and above one thousand) and by type (acute, mental illness, mental handicap, long stay, etc.), recognising the immense changes in the hospital service since 1947 and the impact of those changes on the work situation of nurses and midwives. The number of hospitals with less than 250 beds fell from 2,477 in 1959 to 2,240 in 1970, but thirty-eight per cent of all hospital nurses and midwives were still employed there at the time of our survey, with forty-six per cent in hospitals of 251–1,000 beds, and sixteen per cent in large hospitals with more than one thousand beds. Our survey shows¹ that the nursing and midwifery hospital labour force is distributed between types of hospital as follows: fifty-one per cent in acute hospitals, fifteen per cent in mental illness, four per cent in mental handicap, seven per cent in long stay and chronic and twenty-three per cent in hospitals other than these. Given this list of different situations, it is obvious how difficult it is to generalise about the working world of the nurse;
- (b) in the case of the community services there are equally striking variations of circumstances—in rural and urban areas, for example, and in affluent and socially deprived areas. Large country areas and big cities present nurses and midwives with very special problems. The range of responsibilities varies also. For example, health visitors, who do not carry out direct clinical nursing, employ a particular combination of skills which require adaptation to these different human environments—skills in observation and assessment, in communication and in coordination and planning, along with technical expertise in the promotion of health and the prevention of ill health.

OLD AND NEW IMAGES

87. Inherited images do not mirror this variety within nursing and midwifery. Yet not all images are inherited ones, and attitudes are changing all the time. We have noted in Chapter I the growth of group attachment and its likely further extension. This development brings integration into the present and is already introducing the public to a new conception of the nurse. Some nurses have expressed apprehension about doctors in general practice having nurses attached to them, yet it is encouraging to note that experience of attachment appears

¹ The figures produced by our survey are broadly in line with those produced by the Health Departments although there are slight differences.

normally to dissipate such fears. New relationships are being created which are already changing images. Further integration will change them more.

88. Midwifery, which often links hospital and community services, has already changed substantially, as was shown in Chapter I. We were offered in evidence by the Central Midwives Board (England and Wales) an interesting paper by a consultant paediatrician, which considers the midwife's role in the broadest of contexts. "Since social and cultural influences come to bear upon the child immediately after birth, the midwife must become aware of their results, conversant with the social aid available and how it can be obtained." The importance of such social and cultural factors is as great for nurses as it is for midwives, and we would add that these same social and cultural influences shape the way in which the midwife's role is conceived by the public. The whole development of antenatal services has done more than any other factor to dissipate nineteenth-century attitudes to the midwife.

89. In the London area, in particular, a new image of the nurse has become prominent in recent years. Nurses and midwives from developing countries make up eight per cent of the nursing and midwifery staff in acute hospitals, eleven per cent in psychiatric hospitals and eight per cent in other hospitals in Great Britain, and they have filled in gaps in hospitals with severe staffing shortages. Forty-six per cent of the immigrants, however, are employed in the four Metropolitan Boards, a very high degree of concentration. In later chapters of our Report we discuss particular facets of this situation. Here we note that it is now taken for granted that many nurses and midwives come from overseas. In fact, about half our immigrant nurses and midwives were recruited here and about half from overseas.

90. It says much for the pull and power of nineteenth-century attitudes that some of the most basic of them have survived vast changes in medical and social history, thereby confusing images and contemporary realities. Part of the reason for their persistence lies in the long life and continuity of buildings. Thus, while the design of new hospitals has been transformed, there are sufficient old ones, particularly out-of-date mental hospitals, (sometimes part of the same organisational complex), to influence the attitudes both of staff and of the general public. The era of custodial care is not dead, particularly in some hospitals for the mentally handicapped, where there is serious overcrowding, where there are genuine shortages of trained staff, where the ratio of older to younger nurses is high and where there is an acute shortage of domestic and supporting staff. In dealing with such hospitals, indeed, and with the nursing staff working in them, we cannot avoid considering the legacy of history.

91. We do not wish in this Report to return to the history of nursing for its own sake or to separate out facts or myths except insofar as inherited images influence current attitudes and policies. We have noted, indeed, that current attitudes and policies may be even more strongly influenced by twentieth-century mass media of communication which often succeed in both looking backwards to Victorian Britain and looking forward to the age of integration:

- (a) books and mass-circulation magazines for girls and women frequently deal with "timeless" and "universal" nursing themes: they are read by

large numbers of people, of whom only a few will eventually become nurses. A study of such books and magazines suggests that nursing is thought of as a drama, a drama with a sequence starting with the initial inexperience of the novice nurse and ending either with the achievement of effective control or, less frequently, with disaster. The education of the nurse figures as much in such picaresque writing as the ultimate disposition of her duties. Romantic relationships are basic to the drama: they include relationships centring on jealousy, rivalry and malice as well as virtue rewarded and true love. The juxtaposition of youth and death is also a part of the pattern.

There is also a more realistic vein in some girls' magazines, particularly those which deal with future careers in documentary or semi-documentary fashion. These point to the variety of careers in nursing and midwifery (and the effort needed to pursue them) and by no means concentrate exclusively on the drama. They provide an important medium of information as well as of interpretation. We recommend that these magazines should be made known and their cooperation obtained in providing further and more detailed information relating to nursing and midwifery as a career;

- (b) television series and films seek to create, often successfully, the sense of a separate hospital world of its own with characters and shifting patterns of relationships. In this respect they are like comic strips, some of which, though not in this country, select nursing as a favourite topic. Again it is the drama and the romance which predominate, with great emphasis being placed on the romantic relationships of nurses both with doctors and with patients. A few series have put the spotlight on community rather than on hospital nursing, but it has usually been not the community nursing of the present but that of an earlier period of twentieth-century history.

Serialisation implies concentration on moments of tension, real or contrived. The use of actors and actresses, seen regularly in television series as nurses and doctors over long periods of time, produces a new set of associations diverging sharply, if sometimes only superficially, from the inherited images.

At the same time television also includes documentary films, many of which take as their starting point the divergence between the inherited or contrived image and the "reality" and can play a helpful and constructive part in keeping both the general public and potential entrants informed. The "problem" aspects of nursing are usually picked out in documentaries, usually sympathetically;

- (c) newspapers include a great deal of material, often fragmentary and personalised, about nurses and midwives, not only news material but photographs and feature articles, and sometimes combinations of news, photographs and feature articles, as in the "Nurse of the Year" contest sponsored by the *Daily Express*. In two sample weeks in 1971 which we studied in detail there were on each occasion more than one hundred references to nurses in the press, most often in local newspapers dealing with individual careers or with social occasions, including prizegivings, in the hospital. The national press always has a regular coverage of nursing. Press references cover an immense variety of themes, not least accident

and emergency procedures, ethical questions centring on nursing, petty discipline and, very regularly, uniforms, while during recent years questions of pay and protest have loomed large. Like radio and television, the press has made much also of the "lure" of nursing employment overseas, particularly in the United States and Canada, pointing both to the pay and to the "glamour". Most of the comment is highly favourable to British nurses and nursing, as is the case in unsolicited letters from correspondents, but contrasts are sometimes drawn for effect—with stress on the power motivations of nurses not on their compassion: and with talk not of "ladies of the lamp" but of "dictatorial automatons". "They're the ones who make hospitals into institutions" was one of the most sweeping comments of 1971.

92. In general, nurses as portrayed in the media tend to be women working in acute general hospitals (and these, as we have seen, are only just over half of the whole). Community nursing and hospital or community midwifery sometimes figure, but psychiatric nursing and male nurses very seldom (except in television documentaries). There is some sense of the changes taking place within the profession, particularly those which are taking place as a result of external social pressures, but the role of the nurse is left vague. The character of the material contrasts sharply with that presented in the specialised nursing and midwifery press which is highly professional, critical of routine ways of thinking about nursing and keenly and responsibly concerned with change and its effects.

93. Public images influence recruitment: they also predetermine attitudes at critical moments in the health history of individuals and families. Yet the surface should not be mistaken for the substance, and in any searching analysis of contemporary attitudes attention should be paid not only to images of nurses but to shifting conceptions of dependency, institutionalisation, discipline and, above all, life and death. These conceptions are related both to expectations and aspirations concerning the National Health Service as a whole, and they should never be ignored by either strategic planners or by "managers".

94. They should remember also that new generations of nurses and midwives share some of the attitudes of their own generations more than they share the attitudes of an older generation of nurses and midwives. One of the purposes of our opinion survey was to judge how far this was true. We noted considerable variation in the age pattern as between different types of nursing. In mental handicap hospitals, for example, twenty-six per cent of staff were over the age of fifty-five (as against eight per cent in acute hospitals and twelve per cent in all hospitals). Age proportions matter, and there is a tendency among some of the younger nurses we interviewed to feel that they are being expected to undergo too long and painful a process of initiation before they are fully welcomed into the profession. Senior nurses felt happier about the current situation than students and pupils. As has been shown in Chapter I (paragraph 69), a majority of hospital nurses and midwives agreed that "senior nurses often forget what it was like to be a junior nurse" and the more junior the nurse, the more likely she was to hold this view, and to hold it strongly.

95. Turning to the origins of attitudes towards nursing in a changing society, we did not seek in our own research to duplicate the work of Dr. Jillian MacGuire,

who was one of our advisers. In her study¹ *Threshold to Nursing* (1969) Dr. MacGuire drew upon a number of earlier research reports which showed that about a quarter of all adults in one survey considered nursing to be a “first choice” of career for girls leaving school and saw nursing as the hardest but the most worthwhile of four jobs—nursing, teaching, secretarial work and clerical work in banking—and second to teaching in its demands on “intelligence”. Adults had a more favourable image of nursing than girls aged sixteen to twenty-four, and two out of three in the general population would have been willing to encourage a daughter to take up nursing. The most recent surveys quoted showed that there was more knowledge than there had been at the time of an earlier survey in 1943 about jobs in nursing outside hospitals. Dr. MacGuire also noted evidence that about a third of women and girls developed an interest in nursing at some time of their lives, with the years thirteen to sixteen providing the peak age range for such interest. About one-sixth developed a strong interest. By contrast a small minority of boys of school age interested themselves in nursing. Educational attainment but not social class, family size or geographical location affected interest in nursing. Hours and pay were seen as deterrents; it was felt that there was more “discipline” than was necessary; and change in the profession (for example, in pay, grades and conditions) was underestimated. Information about nursing conditions was frequently wrong. The need for personal suitability was stressed. Little was known by potential recruits about specialisation, age of entry, educational entry requirements (which were over-estimated), career structure or the difference between registered and enrolled nurses. It was felt that it was difficult to become a nurse.

96. Most male nurses, Dr. MacGuire concluded, came to nursing as their second career choice after an unsuccessful attempt at another career and for many it was a positive shift to a more worthwhile job. Psychiatric nursing offered a field where, largely for reasons of history, the image of nursing work as “women’s work” did not hold. More recent confirmation of these conclusions comes from *The Career Intentions of Male Nurses*,² a study of male recruits to nursing by the Department of Social Administration, Hull University, which the authors (Brown, R. G. S. and Stones, R. W. H.) kindly made available to us.

THE IMAGE FORMALLY PRESENTED TO THE RECRUIT

97. We have carefully examined samples of current recruitment literature, including advertisements and other relevant material, in relation to this evidence and to that presented in our own surveys:

- (a) emphasis is now placed in national recruitment brochures on the variety of jobs in nursing and midwifery, and, as well as that for midwifery, separate brochures are produced for general nursing, nursing the mentally ill, nursing the mentally handicapped and community nursing. In the four brochures on nursing it is stressed that “every day is different” and “every patient is different and needs a different kind of approach”. In the *Mentally Ill* brochure a nurse says “you can’t say this is like any other form of nursing. It isn’t”. In the *Community Nursing* brochure a health visitor comments “Our attachment to a group medical practice has meant one

¹ See list of references, no. 67.

² See list of references, no. 6.

very important thing—a great many entirely new interests have been added to the kind of work we used to do”;

- (b) the subtitle of the most recent brochures on *Nursing the Mentally Handicapped* and *Nursing the Mentally Ill* is “A profession for people who care”. The brochure on general nursing has as a title “*Someone Special*”. In the *Community Nursing* brochure a key phrase is “The personal quality which really does count for something is initiative”;
- (c) emphasis is placed on teamwork in all four brochures rather than on individual vocation, though the sense of “worthwhileness” is still underlined and there is somewhat more emphasis on teamwork in the brochure on general nursing and in the brochure on *Community Nursing* than in the brochures on the *Mentally Ill* and the *Mentally Handicapped*. “Satisfaction here is greater than you might be able to discover elsewhere,” says the brochure on the *Mentally Handicapped*;
- (d) all the brochures are personalised: they deal with individual career profiles, some stressing the youth of the nurses being described, others the benefits of “maturity” and “experience”. “The younger generation of nurses certainly contribute their own quota of verve and zest to the job, but the mature nurse brings a very special kind of help to many patients.” The main point is that there is “continual involvement with people and with life”. In the *Community Nursing* brochure, a domiciliary midwife writes “What I have discovered in my work is that you are concerned not only to help the parents themselves but also to teach them—and this is, of course, in addition to giving personal midwifery care”;
- (e) it is not assumed that all entrants thought of being nurses from childhood. One of the girls, an enrolled nurse, says “some girls have wanted to be nurses ever since they were children, but it never entered my head until I saw an advertisement in a paper”: it was her third job. A nurse dealing with mentally ill patients had done a number of jobs before he came to mental nursing, took to it and stayed. Of another nurse who joined the profession late in life it is said “after a spell at home, bringing up her child, she believed that an early ambition to become a nurse need not be forsaken”;
- (f) all deal with educational methods (“up-to-date” and “carefully balanced”) and conditions of living (agreeable). Discipline is said to be “sensible” (with “very good reasons behind the rules”);
- (g) it is recognised that different nurses have different objectives within the profession; “I would like to carry on with further training” contrasts sharply with “I’ve no desire to climb up the promotion scale because I enjoy my present work so much”;
- (h) it is recognised finally that the profession is changing. “Even in the short time I’ve been in mental nursing, things have changed.” There is a “continual willingness to try out new ideas”. “This is a job where you are always learning something new because nursing and medical techniques are constantly being developed or reviewed.” “The very nature of the work,” it is said of the midwife attached to group practice, “demands the use of modern equipment, such as the gas and oxygen machine and resuscitators Many midwives are now carrying radio transceivers to summon help when it is needed.”

98. We have tried to judge the effectiveness of such recruitment material in increasing the number of recruits. Some of the evidence we have received suggests that most recruits learn about nursing not from literature (few admit to having been influenced by advertisements) but from personal contact, often with relatives. Moreover, local factors play a preponderant part in recruitment patterns.

99. The Department of Health and Social Security has been organising national publicity campaigns since 1965, and we have as a Committee followed the progress of these campaigns since May 1970—for example, through a Departmental analysis of coupons which are filled in by newspaper and magazine readers who read national nursing advertisements and write to the Department (or elsewhere) for further information. We have also collected material on recruitment expenditure by hospital authorities.

100. Information is patchy, but the figures show that national expenditure on advertising increased by over twenty per cent per annum (in money terms) during the last two years. Total expenditure on nursing advertising by hospital authorities has also increased by the same amount, although there are considerable regional variations. Almost one-third of the advertising for nursing and midwifery staff comes under the category of “general recruitment advertising”, with the largest specific expenditure being on advertising for qualified staff.

101. We have found it difficult to evaluate and assess the results of the national campaign since economic factors (pay and the general level of unemployment) have changed since the campaign started. We note, however, that regional variations in expenditure are not directly related to the number of nurses required.

102. We take up other aspects of this subject in Chapter V, but in this context recommend that there should be a closer study nationally and locally of the economics of advertising before selective drives are made for particular categories of nurse or potential nurse. We believe that recruiting at national level must continue to concern itself with general images as well as with particular targets, while local advertising should remain directed towards the kind of recruits needed—and available—locally.

103. One of the main reasons for national campaigns is the prevalence of a strong feeling, not least among nurses and midwives, that nurses and midwives are “born not made”, perhaps the most stubborn of all the stereotypes. Nursing and midwifery are not considered seriously enough by young people who have no family or school connections with them and have no idea either of the extent and characteristics of the nursing and midwifery educational system or of the variety of nursing and midwifery opportunities. Even trainees themselves often stick to the stereotypes. After one of them had recently seen a recruiting film she commented “If a girl or boy has decided to become a nurse nothing will change her or his mind If the person doesn’t know what career to follow, the film was of no help.”

104. We have observed that at least one local recruiting campaign for a hospital dealing with the mentally handicapped has successfully subordinated the use of the word “nurse” to the word “care”. This places opportunities in nursing and

midwifery within a broader framework. We agree with a comment made to us in the evidence of the National Association of Leagues of Hospital Friends that "contrary to the image presented by the national news media, there is a large and growing awareness among young people . . . of the obligations which the fortunate members of the community owe to the less fortunate, and a desire sincerely felt, if sometimes inadequately expressed, to do something to discharge these obligations". Emphasis in recruiting on the need for "care" in a complex society and the changing patterns of provision of care is in our view fully justified, and publicity should be given to the estimates of real job satisfaction set out in Chapter I. Nursing and midwifery live up to the most profound of their claims: they make nurses and midwives feel that, whatever the privations, they are doing "something special" and inwardly rewarding.

105. Students in training and to a lesser extent people working in the profession will ask key questions in the light of their own experience about the kind of recruitment material described in paragraph 97. They are bound to treat this material critically, and we believe that their criticisms should be taken into account. Is what has been said about "rules" borne out in practice? Is there really "teamwork" and "a sense of community"? Is the sense of "worthwhileness" realised? New recruits, in particular, will contrast what they observe from experience with what they have been told, and will do this on their own or in the group of students with whom they are involved in training. Some "wastage" can be accounted for in terms of this sense of contrast. In so far as such wastage arises from the fact that actual experience must always diverge from all second-hand paper accounts of experience, it is unavoidable. Insofar as the criticism points to real divergencies between what has been promised and what is actually being offered, there is need to ensure both that shortcomings are, as far as possible, made good, and that general recruitment literature is very carefully scrutinised and frequently reviewed.

106. We collected from a group of nurses in training a sample of opinions on the recent recruiting film mentioned in paragraph 103, which we also saw ourselves and which we thought presented a reasonably realistic (as distinct from a romantic) image of the nurse in her or his modern setting. This aspect of the film was itself criticised. "Certainly this is true life in the ward, but you are thrown into the deep end soon enough without even having started training." While almost all the viewers thought it gave a fair picture of career prospects once inside nursing:

- (a) it was pointed out that modern buildings and modern living conditions are not universal;
- (b) it was argued that for all the realism in those parts of the film dealing with nursing skills, what was said of relationships both between nurses of different grades and between nurses and doctors was idealised;
- (c) it was noted that little was said about the lonely responsibility of the nurse, especially on night duty. In the film there always seemed to be some senior nurse on the scene; even in the daytime there was little sense of "the ordinary, busy ward";
- (d) it was felt that the realism also stopped short in relation to the daily work of the nurse: there was no mention of "bed making, bathing, giving bedpans or cleaning";

- (e) it was pointed out that no male nurses were shown at work in a ward. The only male nurses seen were psychiatric nurses. Given that recruitment films are now seen by both sexes this was thought to be a serious mistake;
- (f) finally a distinction was drawn between the film as a recruitment film and as a statement of "the truth" about the profession, with the following side comments:
 - (i) people at school today, used to documentaries, are not "taken in" by glamourised pictures. "School children looking at possible careers are very critical about things like this . . . the more of a show that people try to put up the more discouraging it is for the young person";
 - (ii) selectivity is dangerous. "They should have shown EVERYTHING", including "the fact that nursing can be a very trying and a very tiring job";
 - (iii) the film as an advertisement for nursing was "good", but would attract "the wrong people for the wrong reasons". "If I were still at school I might be influenced to go into nursing by the film," one student admitted. Yet "disappointments" would be sure to follow. "Yes, it would get your recruitment," one student put it frankly, "but how long would they stay when they see what the true conditions are?"

THE VOICES OF NURSES

107. Such criticisms, which seem to us to reflect clearly the views of the profession in the making, are borne out by more detailed accounts which have been published or submitted to us as a Committee concerning the daily life of the nurse as it is actually lived:

- (a) answers to our questionnaires suggested that dissatisfaction with work, hours, shifts and promotion prospects tended to be less prevalent than we expected, yet:
 - (i) when nurses and midwives who cooperated in our postal survey were given a list of different categories and grades of staff, ranging from messengers to doctors and including clerical workers, social workers, other professional staff and less qualified nurses, and asked to say whether during the last week they had carried out work which ought in their view to have been carried out by one of the other categories, sixty-six per cent of registered and enrolled nurses ticked off at least one item on the list;
 - (ii) a quarter of hospital nurses and midwives and nearly a third of community nurses and midwives had worked "unofficial" unpaid overtime during the previous week and between a quarter and a third of all nurses and midwives had had less than two full days off in the previous week (though we note the possible distortion arising from fortnightly patterns of work allocation and from the fact that the present Whitley agreement on overtime in non-psychiatric hospitals had not come into force at the time of our survey);
 - (iii) while there was less concern with questions of promotion than might be expected—a matter which we discuss fully in Chapter VI—our

interview survey showed that a considerable number of nurses and midwives (thirty-nine per cent) feel strongly that the criteria for promotion are wrong—length of service, in particular, rather than ability, while a further twenty-five per cent share this feeling to some extent;

- (b) turning carefully and critically from our questionnaires to the unsolicited letters sent to us and bearing in mind that many, perhaps most, could be expected to come from people with criticisms to offer, we found some of the same points made more strongly. The letters dwell mainly on the extent of “non-nursing duties” (“sheer drudgery”) and the inadequacy of both personal and organisational relationships. The single greatest cause of complaint was the attitudes and behaviour of nurses themselves (there were fifty critics, including twenty nurses in post, ten former nurses, six doctors, three relatives of nurses and six others) and in the words of one critic “there seems to be a complete disregard for the human being beneath the nurse”. “Training,” says another, “tends to destroy initiative, discretion, common sense and dampens the enthusiasm which most nurses have to get to know and look after ill people”;
- (c) we noted, for example, the comments and criticisms of student nurses, among them one, representative of many, who stayed for only nine months and failed to complete her training. Her comments were on the obverse side of the coin from those presented through the recruiting media. Living conditions were not good. Rules were not sensible. There was too much harshness over trivia and lack of perspective. The preliminary training course was not stimulating, but exhausting. Communications were poor. Questions were not welcomed. The typical day was too long. There was too little time for real care. Everything was institutionalised. There seemed to be an almost perverse desire to “preserve the [unfavourable] image at all costs”. Others complained, however, from a quite different angle, that “nursing procedures” had to be undertaken “without adequate demonstration and supervision”. “Sisters and staff nurses are too busy to do more than distribute cursory directions with minimal teaching of procedure. The more conscientious and idealistic the student nurse is, the more likely she is to be troubled by this lack of teaching”;
- (d) from the other side a nurse administrator concerned with the allocation of student nurses wrote that she found “students remarkably understanding and helpful even when refused a request if told why”. She added that “the tensions due to medical advancement are greater than when we were students” and that “some sisters are threatened by a knowledgeable student, or the one who uses initiative which is appreciated in an emergency only”;
- (e) we have read a number of accounts of personal experiences in nursing, both published and unpublished, mainly by recent recruits to the profession. Almost all emphasise the shifts in responsibility associated with daily work—at one moment, independence, sometimes frightening independence; at another subordination, sometimes oppressive subordination. “Everyone assumes if you’re in uniform you know everything. I was in uniform for the first time and only conscious that I knew nothing.” Some go further and talk not only of shifts in responsibility but of inherent ambiguities:

“The nursing profession is in a peculiarly ambiguous position: so closely connected to the medical profession that it cannot, and must not, be viewed alone—yet it needs to maintain a quite distinct professional identity; forced to provide a twenty-four hour service, seven days a week, yet it depends almost entirely on female labour, which for social and domestic reasons prefers to work regular 9 a.m. to 5 p.m. hours, five days a week. Nurses are removed from the fear of unemployment, but train for a qualification which fits them to do no other job. Potentially nursing is a job which can provide great reward and satisfaction, but the number of nurses who leave during training or once they have qualified shows that it fails to realise that potential, and today nursing must compete with many other professions which are open to women and which appear more attractive in so many ways. Among nurses, a wide range of skills, abilities and responsibilities commands the same salary and status; intellectual ability within one rank varies from minimal secondary school achievements to university degrees, but the nurses with high intellectual or technical skills are not fully utilised.”

108. We do not subscribe to all these personal opinions, some of which are flatly contradicted by more general evidence submitted to us, for example in reply to our opinion questionnaires. From the questionnaires it emerged that most nurses and midwives seem willing to shoulder the burden of responsibility imposed upon them: only a third of hospital nurses and midwives and a fifth of community nurses and midwives agreed with the statement that “too much responsibility for difficult decisions about the care of patients is left to nurses”. While over half (fifty-nine per cent) of hospital nurses and midwives agreed with the statement, “there is too much variation in levels of responsibility from day to day”, only twenty-nine per cent of community nurses and midwives agreed. Not surprisingly student and pupil nurses were the most likely to agree (seventy-five per cent and sixty-six per cent respectively). There is a different side to nursing and midwifery, therefore, from that expressed by nurses or midwives with grievances before or after training. We note that after initial difficulties, some of which seem to us to be a necessary part of the process of becoming a nurse, nursing offers to many people “enjoyment and satisfaction” in a way that few other professions do. “I’ve never met a nurse who can’t find something to moan about,” one of them writes. “Yet, whenever I am asked if I enjoy nursing. . . I say, yes, it’s a wonderful life. Compared with chasing after money, it is. Compared with the rat race of office life it is. Compared with living in luxury on a Pacific Island it probably isn’t. But, then, who gets that chance?”

109. Relevant criticisms, justifiable or not, often focus attention on critical relationships at work. Some point to the difficulties which the part-timer can experience, others to the fact that “staff nurses are not trusted”. “The conflict aroused in most nurses between doing their duty as dictated by ward administrators and doing what common sense insists is not good patient care causes both anxiety and frustration.” Almost all direct attention to the key role of the ward sister. “Any senior nurse who has worked on a particular ward or department for some time, and has confidence in her own technical ability, can break slightly from the traditional inflexibility of nursing and mould her own work among both patients and juniors, with initiative, discretion and sensitivity. The

ward or departmental sister is the key person there: her powers vary according to the administrative policy of the hospital; they are likely to be greater in matters concerning patients than in matters concerning the nursing staff. Her own personality is important in creating the atmosphere most conducive to happier nurses and patients The sister often has considerable control over the off-duty, she can rarely dictate the hours of the shifts worked, but often arranges the weekly off-duty schedule and can deal sympathetically, or not, with requests for special off-duty Most important of all, she has the power to affect the morale of the whole ward, more even than it is affected by the nature of disease cared for in that ward. Her own behaviour in a crisis determines the confidence that the nurses have, not only in her, but in the knowledge that were something unexpected to occur while they were treating a patient she would support them; such confidence generated to the junior nurses is easily felt by patients as well. A ward sister needs to be perceptive to notice the nurse under stress, or the nurse who is disturbed by an event or a particular patient. In dictating her own priorities, she can affect the welfare of both patients and staff: should tired nurses go for their tea breaks or tidy the sluice? is she content if the patients are comfortable or must they look neatly arranged? are the most ill patients in a position where not only can the nurses see them easily, but so too can young, newly arrived patients? It is the ward sister who must always be available to patients, their relatives and the nurses for advice and reassurance in all problems; then she alone can combine the roles of all members of the medical team to present a clear pattern of treatment and progress that they can all understand. She should attempt to know each patient's family so that from her explanations and reassurance they are able to appear less anxious. Fear of the unknown is probably the greatest fear of patients, relatives and nurses, and the ward sister is in the best position to dispel those fears. The respect which all sisters should command, should not be the awesome respect of a subordinate, but a respect based upon the ward sister's competence and skill in nursing and management."

110. Later in our Report we turn to the range of points raised in this comment on competence, skill, teamwork and delegation in relation to patient care. We conclude our brief comparison of images and realities with three basic points:

- (a) there is an immense variety in the practice of different hospitals and local authorities, such a variety that it is almost impossible to generalise. If good practices in the best hospitals and local authorities were to be adopted more generally there would be immediate and in some cases striking improvements;
- (b) individual disillusionment often sets in most quickly in relation to practical matters, particularly hours of work, days off duty, shift working, night duty and the duty rota. Yet not all the "images" of discontent are backed by facts. For example, in response to a statement in our questionnaire that nurses were asked to undertake too much night duty, it was found that a large majority of nurses and midwives disagreed. From a list of eleven suggestions for improving conditions less night duty was the least popular, the selection figures being only two per cent for both hospital and community nurses. In our survey of qualified female nurses not at present in the profession, we asked those intending to return to nursing who said they would have to arrange their hours of work to fit in with family commitments about evening and night work. Just under a half

said they would be prepared to work during at least part of the period 5 p.m. to 10 p.m. and about a third between 10 p.m. and 9 a.m.;

- (c) when nurses and midwives were asked what were their first and second priorities for improved conditions only two items attracted the attention of more than a small minority—the length of the working week and pay. The following table sets out the responses first of hospital nurses and midwives and second of community nurses and midwives:

TABLE 5

PRIORITIES FOR IMPROVEMENT AS IDENTIFIED BY HOSPITAL AND COMMUNITY NURSES AND MIDWIVES

	<i>Hospital nurses and midwives</i>	
	<i>1st choice*</i> %	<i>1st or 2nd choice</i> %
A reduction of hours in the working week	28	45
More basic pay	27	40
Better shift systems	10	23
More weekends off	9	23
Better allowances for special duties	7	18
No extra duties without payment	5	12
More opportunities to earn extra money on paid overtime	4	11
Less night duty	2	5
Better notice of changes in off-duty	5	12
Don't know	5	14

	<i>Community nurses and midwives</i>	
	<i>1st choice*</i> %	<i>1st or 2nd choice</i> %
A reduction of hours in the working week	13	24
More basic pay	31	47
More weekends off	3	11
Better allowances for special duties	11	26
No extra duties without payment	4	11
More opportunities to earn extra money on paid overtime	5	11
Less work at nights	2	3
Less time "on call"	11	20
Better distribution of work between nurses	17	31
Don't know	5	17

Source: Interview survey.

* Columns do not sum to 100 or 200 per cent as some nurses and midwives were unable to decide on only one first choice.

111. After examining together all the criticisms and hopes of improvement, we wish to stress that unless sympathetic care within nursing and midwifery administration is shown to nurses and midwives both in training and after they are trained, the wider claims of the profession to rest on individual care will

ring hollow. Care starts with the relations between nurses and nurses. So, too, does sympathetic understanding on which all care is based. We note in this context, as we did in Chapter I, the deep concern expressed by individual nurses and midwives about procedures concerning ward progress reports which seem to fix their own individual images; and while recognising the need for appraisal of individuals' progress, we emphasise the importance of counselling and consultation. We return to this subject in Chapter VI.

THE CRUCIAL IMPORTANCE OF CARE

112. In examining images and realities we turn next, therefore, as we did in Chapter I, to the concept of care itself. Patients will compare images and realities in the light of *their* experience. They may start with stereotypes, but they will go on to judge nurses and midwives by how they find them.

113. All professions which deal directly with people in need—and they include nurses, midwives, doctors and social workers as well as others—must rest on care for human beings, whose needs cannot be fragmented. Nurses and midwives probably live up to their image and have a stronger sense of responsibility for continuing and unremitting care than any other profession. They provide that care to patients irrespective of the illness from which they are suffering or which they risk incurring. In a divided health system the care can be thought of primarily as either “episodic” (care of the type mainly given in hospitals, which is curative and restorative) or “distributive” (care of the type mainly given in the community, care which is essential for health maintenance and disease prevention). In an integrated National Health Service the two kinds of care can be directly related to each other within a single service.

114. Yet we note (*a*) that there is often not enough emphasis on “care” in nursing education and (*b*) that in planning the future of the integrated National Health Service, it must be recognised that the quality of personal care, to which we attach so much importance, is not easily measurable, whereas many other elements in the National Health Service are. The price of failure or error in nursing or midwifery may be high, but it is not easy to go further than we have done in this chapter. Miss J. McFarlane in her paper¹ on *The Proper Study of the Nurse* emphasises that to establish criteria of quality is a highly complex task and that “part of the complexity lies in the complexity of nursing itself”.

115. Other British studies have suggested that it is almost impossible to isolate the contribution of nursing care from health care as a whole or from medical care in particular. Hence in using measures of patient welfare it is not easy to demonstrate any direct causal relationship derived from the quality of nursing care as distinct from the care provided through the total system. In the United States, where research is at a premium, the National Commission for the Study of Nursing and Nursing Education² commented appositely that “we are dismayed that so

¹ See list of references, no. 70.

² See list of references, no. 65.

little research has been done on the actual effects of nursing intervention and care; the profession has few definitive guides for the improvement of practice”.

NURSING AND NON-NURSING DUTIES

116. The alternative to planning in terms of patient care is to plan nursing and midwifery work, as it has been planned conventionally, in terms of lists of duties. Such planning immediately leads to a protracted argument about the borderlines between nursing and non-nursing work and between midwifery and non-midwifery work. Historically there have been no clear boundaries, and as late as the Wood Report¹ published in 1947, first-year students were said to be spending thirty-three per cent of their time on domestic work, second-year students twenty-four per cent and third-year students sixteen per cent.

117. The responses to our questionnaire revealed clearly—as did the responses to the recruiting film—that it is non-nursing “chores” which seem to most nurses and midwives in training and later to separate image and reality. Thirty per cent of the hospital nurses and midwives (including fifty-three per cent of student nurses) felt that they had in the previous week carried out at least one duty which could have been carried out more appropriately by messengers, and forty-five per cent (including sixty-nine per cent of students, fifty-seven per cent of pupil nurses and fifty-two per cent of midwives) felt that they had in the previous week carried out at least one duty which could have been carried out more appropriately by domestic staff. The comparable figures for community nurses and midwives were twenty-five per cent who felt that they had in the previous week carried out at least one duty which could have been carried out more appropriately by messengers and seventeen per cent who felt that they had in the previous week carried out at least one duty which could have been carried out more appropriately by domestics. Fifty-seven per cent of health visitors felt that at least one piece of clerical work they had undertaken in the previous week should have been done by others.

118. The hospital figures particularly are disturbing, but all the figures reflect a widespread opinion that there is a waste of skills in nursing and midwifery. This sense of waste persists despite the repeated efforts that have been made of recent years to reduce non-nursing duties to a minimum. Both the Standing Nursing Advisory Committee² and more recently the Salmon Committee³ made recommendations on this subject. Successive Secretaries of State have emphasised the need to conserve precious nursing skills. The work of domestic staff has been reorganised in various ways. Yet while a number of our correspondents suggest that the wholesale delegation of non-nursing and non-midwifery duties diminishes the interest of nursing and midwifery and particularly in small hospitals and in the community may create organisational problems, our surveys show that nurses and midwives themselves still see much room for improvement.

119. We do not ourselves wish to draw clear-cut distinctions between nursing and non-nursing work. Some health duties may, according to the condition of the patient, be nursing or non-nursing or even “semi-nursing”, to introduce a third

¹ See list of references, no. 56.

² See list of references, no. 12.

³ See list of references, no. 79.

category; and in certain circumstances what appear to be non-nursing or non-midwifery duties, like cleaning an isolation cubicle, will have to be performed by nurses or midwives. Detailed analysis of a formal kind, therefore, cannot be a complete guidance to policy, which should focus on the proper deployment of personnel.

120. We emphasise that any attempt to list or to define tasks which nurses and midwives may or should leave to non-nurses and non-midwives must be made on the definite understanding that the decision about which tasks to delegate in relation to which patient should be made in the working situation by the trained nurse or midwife at the time. Furthermore, except in the case of small isolated hospitals or in similar unavoidable circumstances, tasks belonging to other groups of staff should not be handed over to nursing or midwifery staff on a routine basis. Staff shortages, whether of domestic staff or of other professions, should not be made an excuse for the persistent misuse of nurses and midwives.

121. We believe that:

- (a) central services in hospitals can continue to be usefully extended (for example, admissions, porter and messenger services, sterile supplies, cleaning, central linen, washing up etc.), noting, however, that a high level of central services may make only marginal differences to the involvement of the nursing or midwifery team in "non-nursing" work;
- (b) there should be full support for the nursing or midwifery team in the ward itself. Substantial savings of nursing or midwifery time—up to twenty per cent—can be achieved by (i) providing staff to cover, under the direction and control of the ward sister, clerical and other non-nursing duties, especially those that are patient-orientated but do not require nursing or midwifery skills and (ii) ensuring that ancillary grades suitably supervised meet the domestic cleaning and allied requirements of the ward;
- (c) similarly, full clerical and other support should be available to community nurses and midwives within the group practice or other centre from which they work;
- (d) there should be maximum use of aides both in the hospital and the community and their work should be related very directly to the work of other members of nursing or midwifery teams; and
- (e) there should be a clear understanding that nurses and midwives are not used at weekends and during night shifts to discharge essential services which should be discharged by others.

NURSING AND MIDWIFERY TEAMS

122. Listing duties is inadequate and misleading, not only in relation to drawing the borderlines between nursing and non-nursing work, but to distributing responsibilities within the nursing or midwifery team itself. Much of the frustration expressed to us in evidence from nurses and midwives and ex-nurses and midwives seems to arise from a production-line concept of care, whereby the nurse or midwife does not care for a group of patients as individuals but performs repetitively tasks (such as bedpan rounds) which reduce the patients to a series of functions. This is often said to be the only way of reducing the nursing and

midwifery workload to manageable dimensions. Yet at its worst such an approach may make the routine more important than the patients.

123. We believe a more positive approach is both possible and necessary. We emphasise the word "approach". We are convinced that the right approach is a patient-orientated one, but in stating our conviction we wish to add that this approach can be achieved by means of a variety of systems. However work is organised, it can be analysed in terms of tasks to be performed; the important thing is to keep the focus on the patient at all times as the centre and origin of all the activities undertaken. In carrying out these activities, each nurse or midwife should be able to contribute her own separate skills and personal aptitudes.

124. Our surveys showed that only thirty-one per cent of nurses and midwives personally favoured a system of task allocation. Over half regarded patient allocation as more efficient, sixty-five per cent thought it better for the teaching of nurses; most important, no less than seventy-one per cent thought it best for the comfort of the patient. Yet in acute hospitals sixty-one per cent of the work is allocated by tasks. The contrast between preference and reality engenders considerable discontent. While in surveys of this kind terms like "task allocation" and "task orientation" and "patient allocation" and "patient orientation" lend themselves to varieties of personal interpretation, however careful an attempt is made to define them, and while many respondents lacked experience of their preferred system, it is clear that a substantial majority of nurses and midwives want a system of work allocation which puts the patient in the centre of the picture.

125. How patients are grouped will affect the way in which nurses and midwives are best organised to care for them. Even in the traditional Nightingale wards in hospitals the concept of selective patient care was tacitly recognised in the matching of nurses to patients. The patients who were most ill lay opposite the ward sister, seated at her desk, while convalescent patients progressed to the end of the ward to be nursed by probationers. Nowadays, the concept is formalised in the development of intensive care units, for the one to two per cent of patients so critically ill as to need constant, individual, skilled nursing, frequent attention from doctors and access to special equipment and facilities. At the other end of the spectrum are patients who are almost ready for going home and now need little or no nursing care. Most patients still fall in the area of "intermediate care", which covers a very wide range of dependency on nurses and midwives and means that within a single ward, there is often scope for grouping patients according to the level of nursing or midwifery skill required.

126. There are valid arguments against the extreme application of the principle of selectivity, but extreme application is not what we advocate. Separate care should continue to be given to the small groups at either end of the scale; those requiring to be grouped for "intensive" care and those requiring least medical and nursing care whether in the hospital or community context. Within the much larger group requiring "intermediate" care, we see scope for ward sisters to deploy their staff imaginatively, matching skills to needs. In order to achieve this objective ward sisters must think of themselves (and be thought of) as leaders of nursing or midwifery teams rather than as supervisors of individuals carrying out set tasks.

127. The image of the nurse as "the lady with the lamp" concentrated on the heroic qualities of the individual nurse. Yet nurses and midwives worked together in teams in periods of greatest emergency, and we believe that it is through the effective development of nursing and midwifery teams that we can make the best use of nursing and midwifery resources in this country. No single nurse or midwife can maintain a comprehensive and continuous oversight of patient care herself, and we regard the team as the basic group of nurses or midwives concerned with patient care. With the increased sophistication and expectations of patients, the change in tempo associated with the higher rate of patient turnover in hospitals, the increasing use of auxiliaries and the more intensive medical, nursing, midwifery and other treatment received by the patient, the responsibility of the nursing and midwifery teams to establish patient confidence is becoming more onerous. There must be better caring, not least more concern with psychological as well as physical needs, more interest in the individual patient.

128. Within the hospital the composition of the nursing or midwifery service team must be related realistically and flexibly to the changing health needs of the patient on the one hand and to the availability of health resources, especially qualified manpower, on the other. The key figure in the ward team is, and will always continue to be, the ward sister. In recent years, ward sisters have come under increasing pressure both on their time and on their reserves of energy and character. We have examined work study evidence that in a not untypical day, the vast majority of a ward sister's activities may each last for less than a minute; the pattern is one of frequent interruption and multiple responsibilities, often for minute details. We regard it as imperative to find some ways of relieving the burdens on ward sisters, and freeing them from day-to-day minutiae so that they can devote their attention to the overall planning of care in their ward, with more time to exercise their clinical and teaching skills. They will need help, encouragement and support in this new role.

129. We relate to this need the further need, which we have noted elsewhere, to review the position of the staff nurse. This is a grade in which we have identified special problems and noted anomalies; it is a grade which for many nurses, particularly older married women working part-time, is that in which they will spend the rest of their professional lives, while for others it is a staging post in their progress towards charge of a ward. It is not recognised as a career grade in its own right; there are wide fluctuations of responsibility; no real preparation for a senior post and little control over the organisation of work.

130. We believe the answer to the problems of pressures on ward sisters and frustration among staff nurses can only be found in developing the concept of the team within the ward itself. The art of matching nursing and midwifery skills to patient needs would be the hallmark of the competence of the ward or midwifery sister or of the staff nurse or midwife to whom she or he had delegated this responsibility. In situations where the work load in the ward does not vary greatly, where the types of illness and the degrees of patient dependency are similar from day to day, and where the quality and numbers of nursing and midwifery staff do not fluctuate, the division of the ward team into groups might be the regular method of nursing the patients in that ward. Where, however, there are marked changes in these features from day to day, even from hour to

hour, there should be no rigid allocation of patients to fixed groups of nurses or midwives within the ward team as a whole.

131. The activities of the groups of nurses or midwives mentioned above should be coordinated by the senior nurse or midwife in each group. In certain circumstances, depending on the degree of responsibility, we recommend that this nurse or midwife should be designated as senior staff nurse (or midwife). He or she would have recognised responsibility for the team. The ward sister's role in this context would be to formulate policy and set objectives for the senior staff nurse, who would be free to plan detailed implementation and to coordinate the pattern of her or his work within the ward sister's overall policy. This particular post might be suitable for a nurse or midwife working part-time. The team she or he would coordinate would include a range of skills provided by herself or himself, other Registered nurses or midwives and Certificated nurses (see below Chapter IV) and support from aides.

132. Students would contribute to the work of the team whilst gaining experience in controlled situations under the supervision of nurse or midwife teachers and their clinical seniors on the ward. They would thus secure the valuable opportunity of discussing together the work of the team as a whole.

133. Although the numbers of nurses or midwives in a ward affect the work that can be done, the principles of patient orientation always apply. The concept of teamwork is unaffected however few nurses or midwives there are on a ward provided they constitute a balanced team. To be successful in practice this approach presupposes that:

- (a) there must be maximum cooperation and maximum delegation within the team to draw out the full potentialities of each individual nurse or midwife; seniors must work with juniors and take the opportunity to teach; ward sisters must evolve ward policies, set objectives and monitor progress, leaving matters of detailed implementation to whoever is leading the team;
- (b) other members of the health team, particularly doctors, must learn to accept the consequences of delegated authority, which may mean that a relatively junior nurse or midwife is the right point of contact.

134. With the introduction of such a system, we believe that ward sisters would be freer to exercise the full range of their skills at the proper level, staff nurses would have a fuller and more satisfying role with better preparation for future higher posts, and patients would benefit from more continuous and better-integrated care. Discrepancies between expectation and reality in the nursing and midwifery professions would be greatly reduced.

135. Some teamwork already exists in the community service. We regard its continuation and further development as indispensable, beginning with family health teams which will operate increasingly from purpose-built group practice premises and health centres. These will become as familiar a part of the landscape as hospitals became in the nineteenth century. We do not necessarily envisage separate nursing teams (with team leaders) within each group practice or other centre, but rather a further development of family health teams attached to group

practices, working from premises where records and information can be shared. They should be available for mutual advice and support in the interests of the patient or family. By working in partnership within health care teams nurses in the community will be better enabled to cooperate with each other, with social workers and with hospital nurses. Whereas the family clinical sister will provide care for all patients on the general practitioner's list who require clinical nursing, the services of the family health sister concerned with preventive health will be available to the entire population covered by the group practice and will extend into the field of the school health service.

136. The family health teams would also include Registered nurses, Certificated nurses, nurses in training and aides, some full-time, some part-time. The numbers of ancillary staff in the community nursing services in England and Wales doubled between 1968 and 1971. Their inclusion in the community nursing team involves senior nurses in the exercise of management and organisational techniques, and already the proper deployment of ancillary help has led to an improvement in morale and performance on the part of professional nurses and midwives. It should be noted, however, that while the use of auxiliaries for work hitherto performed by skilled staff may appear to ease the nursing load, this is not necessarily the effect in practice since their employment often serves to extend the range of care and enables the health authority to meet community needs which could not previously be met with the available manpower.

137. Whether nurses are in hospital or in the community; working as part of a team or alone; whether they are tending the physically sick, the psychiatrically disturbed or the mentally handicapped; whether they are counselling young mothers or elderly people; whether they are nursing neonates or attending the dying, their central role is to ensure the care and comfort of the person being nursed, to maintain oversight and coordination of that care and to integrate the whole—both preventive and curative—into an appropriate social context.

BORDERLINES

138. Once the unique role and function of nurses and midwives in relation to other health service professions and staff is recognised, it is possible to discuss the dovetailing, overlapping, coordination and collaboration which must take place between different members of bigger health teams. Within the bigger team there is a specific area of activity unique to each group based on knowledge and experience and it is necessary to ensure that each of the health professions recognises the extent of competence of the others, with all groups using, where possible, common systems of measurement and recording.

139. We recognise, however, that (a) in the best interests of patient or client care there will be occasions when "borderlines" will have to be crossed and (b) changes have taken place, are taking place and will take place which will lead inevitably to some rearrangement of the boundaries. These should be charted, when possible, so that policies can be planned.

BORDERLINES: NURSES, MIDWIVES AND DOCTORS

140. Turning to the pivotal relationships between doctors on the one hand and nurses and midwives on the other, we note that all medical activities and develop-

ments affect nursing and midwifery directly or indirectly. We believe that while doctors, nurses and midwives are permanent partners in care, it is possible to distinguish in the first instance between the caring role of nurses and midwives (which involves coordination and continuity) and the diagnostic and curative functions of doctors: both have teaching and research functions.

141. We believe in this context that it is essential from the start to dispel the notion (supported though it may be by generally accepted images) that nursing and midwifery constitute a substitute profession for medicine which is entered by girls of lower academic ability or from poorer families. Nurses and midwives must maintain a distinct professional identity.

142. We believe that medicine and nursing and midwifery will remain distinct but related professions in the future. Examining their future relationship, we note that:

- (a) the roles of doctor and nurse or midwife are complementary, with the relationship between nurses and doctors in intensive care units, or that between obstetricians and midwives, providing obvious examples of close working relationships in which both partners learn from each other;
- (b) on particular occasions their roles may be interchangeable, for example during confinements, in counselling patients or in supporting relatives in anxiety or bereavement;
- (c) in situations where the "curing" function (as distinct from the caring function) is subordinate or non-existent (for example, in the case of the chronically disabled or the terminally ill) the role of the nurse is central;
- (d) in situations where there is a high degree of risk, particularly in acute admission wards and intensive therapy units, the intensity and complexity of treatment being provided—in certain circumstances, also the novelty of such treatment—may make it difficult to define specific nursing functions. Close teamwork in such situations will ultimately enhance expert knowledge in each professional group;
- (e) where treatment or care cannot be adequately maintained by other professional members of the health team because of insufficient staff or workload inadequate to justify the employment of specialist staff in small hospitals or units, nurses and midwives, on account of their availability and continuity of service, are usually the staff expected to attempt to take over the functions of other specialists. Conversely, sometimes the doctor will have to attempt to carry out certain nursing or midwifery duties. In the interest of providing the best available service there must be maximum cooperation whenever such situations arise.

143. Given the continuing distinctness of the two professions, we would add that some of the differences between the two groups are becoming less noticeable as doctors become more involved in comprehensive care and environmental needs and nurses and midwives in more sophisticated care and cure techniques based on medical science and an increased input of research into nursing practice. The vital need is for the two groups to communicate their professional knowledge and skills even more closely and consistently as integration proceeds. For nurses and midwives this means accepting the greater input of medical science and technology in

physical and psychological care and accepting responsibility for certain old medical/new nursing techniques so long as these provide nurses and midwives with the opportunity of planning and coordinating more comprehensive care.

144. Good relations between doctors on the one hand and nurses and midwives on the other have a marked influence directly on morale and indirectly on the patient's response to treatment. Doctors who agree to discuss with the nursing or midwifery administration questions concerning admissions or discharges (which can involve difficult decisions), operating theatre lists, times of clinics, ward rounds etc. and their effects on the patient's day, and the introduction of new units, are more likely to have more efficient and reliable nursing and midwifery colleagues than doctors who act unilaterally with or without concern for the nursing or midwifery consequences.

145. There are various medical practices which have an adverse effect on nursing and midwifery staff. Most of them are caused by lack of adequate communication, though some reflect pressure on doctors' time and the fact that doctors do not always concern themselves adequately (nor have they in the past been educated to concern themselves adequately, though attempts are being made to change this situation) with the proper management of health resources. Examples of widespread complaints which we have collected from nurses and midwives include:

- (a) possessive attitudes towards particular beds in a ward;
- (b) admission of patients to wards without consultation which can cause overcrowding;
- (c) too many separate medical rounds performed in a day, taking up a great deal of the nurses' time;
- (d) poor communications between doctors themselves;
- (e) lack of orientation of some overseas doctors;
- (f) the reluctance of some duty doctors to see patients at night, encouraging the nurse or midwife to make decisions of her own;
- (g) research planned and prepared by the medical staff without consultation with nursing or midwifery staff, but which involves the nursing or midwifery staff in a considerable amount of work, for most of which they receive no recognition;
- (h) the installation without consultation and sometimes without consideration of its staffing implications, of technical equipment in wards, equipment which is initially under the entire control of the medical staff and then has to be monitored by nurses or midwives;
- (i) the planning of new units or other developments without consultation on the staffing implications.

146. We stress that these complaints apply only to a minority of doctors, and that a good deal of praise for doctors has also been forthcoming from nurses and midwives. What we would hope to see in future would be a change of attitude among those doctors to whom one or more of the complaints listed above applies, so that ultimately all live up to the standards of the best.

147. Doctors could doubtless list large numbers of complaints about nurses and midwives. Cooperation is a two-way matter. Yet we consider it necessary to draw attention in this connection to one of the results of our opinion survey. We asked those interviewed whether they felt that “when doctors discuss patients with nurses, they take no account of the nurses’ skill and experience”. Seventeen per cent of hospital nurses and midwives agreed strongly, twenty-three per cent agreed slightly, twenty-two per cent disagreed slightly and thirty-one per cent disagreed strongly. The distribution of answers suggests that relationships between doctors and nurses and midwives vary considerably in different settings. When there is such a range of variations there is obvious scope for improvement.

148. The infiltration of nurses and midwives into the diagnostic and therapeutic spheres is not necessarily harmful to the patient if medical supervision is good. It is the quality of patient care which should be the criterion. It is plain that, as we were told by bodies representing branches of the medical profession, doctors are increasingly needing more nurses and more technical and highly trained nurses to assist them in new forms of treatment. One large London teaching hospital, for example, is currently using forty full-time registered nurses to nurse a maximum of ten patients in its intensive care unit.

149. We believe that at all times and at all levels there must be the most thorough and continuing discussion between the two professions in relation to particular medical developments—for example, group psychotherapy, first visits in group attachment, chest auscultation, cervical smears for cancer detection, diagnosis by microscopic examinations in venereal disease departments, intravenous therapy, renal dialysis, the use of anaesthetics in midwifery, the intubation of newborn babies and forceps application in midwifery. It should be decided in each case which duties should be performed only in exceptional circumstances by nurses or midwives.

150. We do not consider, however, for reasons which we have already spelt out, that the future of the nurse or midwife lies in her becoming a junior medical assistant. The image of the *Feldscher* does not in our view fit into the health pattern of this country. If the nursing and midwifery profession were to be expected to undertake a greater proportion of the more frequent, boring, inconvenient or time-consuming of the doctor’s tasks, because of a false assessment of the similarities between the two professions, then the caring function, to which we attach such basic importance, could be jeopardised. Some of Florence Nightingale’s comments on doctor and nurse are still relevant. She said on one occasion¹ it was the nurse, and not the doctor, who fulfilled the all-important function of supplying the vital force. “Usually it is the Medical staff who have injudiciously interfered as ‘Master’,” she wrote also², “. . . Don’t let the Doctor make himself Head Nurse.” Images may change, like medical science, but some of the truths of the past deserve to be reiterated.

151. It was remarked recently that “with the arrival of chemotherapy and antibiotics the nurse became ousted as the chief means of removing suffering”. Yet significant as the new scientific developments have been, they have not changed the role of the nurse or midwife. She is not one of the doctor’s means of treating patients. She is the person who cares for and coordinates the care of the people

¹ See list of references, no. 85.

² See list of references, no. 84.

who are her patients. The health team must recognise such essentials if it is to make the best use of all its members.

152. In considering the relationship between doctors and nurses we turned finally to the legal position. A nurse or midwife, whether working in the community or in a hospital, has a legal duty of care towards her patient. In giving this care she is required to exercise the degree of knowledge and skill which could reasonably be expected of one trained in her particular profession. If she falls below this standard and the patient is thereby harmed she will be regarded as negligent in common law and will be legally liable for the damage resulting from her negligence. Where a nurse or midwife is on the staff of a hospital or local health authority and acts negligently the hospital or local health authority, as employer, in addition to the nurse or midwife will be legally liable for any harmful consequence of these actions. A nurse or midwife may be exempt from legal liability for her harmful actions, however, if she is acting under the direct orders of a doctor "where he is in authority over her" and a nurse or midwife in training may be similarly exempt if acting under the direct orders of a doctor or qualified nurse or midwife "where they are in authority over her" and the harm was occasioned as a result of the orders given.

153. While it follows, therefore, that nurses and midwives should be required to undertake only those duties which through their training they are competent to perform, there is no legal reason against the continuation of the existing practice that the division of work between nurses and midwives on the one hand and doctors and members of other health professions is governed by whatever specialisation of knowledge and skill turns out to be most effective in practice.

BORDERLINES: NURSES, MIDWIVES AND OTHER GROUPS IN THE NATIONAL HEALTH SERVICE

154. Advances in knowledge have led also to the creation in this century of a number of new professions dealing with specialised para-medical services and to the emergence of groups of technicians within the National Health Service. Yet the assertion sometimes made that nurses and midwives have relinquished most of their work to other professions is as misleading as to state that the development of pharmacology, biochemistry and bio-engineering has reduced the need for the training and employment of physicians and surgeons. The work of some of the members of these new professions brings them into direct contact with patients and they have both established their own images and generated their own patterns of recruitment.

155. Nurses and midwives tend to know too little of the background and consequences of this development and of its significance for them. For example, nurses and midwives in training are usually given inadequate insight into the work of occupational therapists. The Occupational Therapists Board of the Council for Professions Supplementary to Medicine in their evidence to our Committee explained that while nurses may "realise that the hemiplegic patient needs instruction in such matters as getting in and out of a bath, or putting on stockings", too often they do not know who is trained to give it. "Too many patients", their evidence went on, "are liable to be discharged to homes quite unadapted to meet their needs, and without any training in adaptation to their new limitations, whether they be physical, psychiatric or a combination of both." In the interests of

the continuity of care in an integrated National Health Service it is essential that all caring professions should thoroughly understand each other's roles and work cooperatively in teams. Such teamwork is particularly important within the hospital setting where the time-scale is shorter and delay in communications less often rectifiable.

156. As we have said in paragraph 120, nursing and midwifery staff should not normally undertake on a routine basis duties properly belonging to other professional groups. There is an overlap, however, between physiotherapy and nursing, and between radiography and nursing, and there is some disagreement as to whether the techniques employed by physiotherapists in intensive care units could equally well be employed by nurses. We have noted a strong feeling in the profession, with which we sympathise, that since nurses and midwives provide a twenty-four hour patient service, other professional groups forming part of health teams must be prepared to provide a similar service when necessary.

157. We welcome the recommendations in the report¹ of the Remedial Professions Committee set up by the Council for Professions Supplementary to Medicine (the Oddie Report, 1970) and also in the statement² by the Committee on the Remedial Professions (1972), that aides should be employed in the remedial professions. We believe that the less complex remedial procedures would be better performed by specialised aides who had received training from a qualified professional than by nurses or midwives who had received no formal training. Thus, a better service would be given to the patient.

158. We recognise that there are areas outside the wards, e.g., in large radiology departments, where permanent nursing staff may be required to carry out nursing duties, and we note that there is an overlap area in relation to the monitoring of patient information. In this connection, as in others, we believe that close co-operation between nurses and other grades of staff is essential.

159. We recognise the importance of the work of technicians in health care, and recommend that when such work involves the continuing repetition of more or less highly skilled tasks unrelated to the planning, coordination and implementation of nursing and midwifery care for the patient, such work should be carried out not by nurses or midwives but by technicians. Such work is particularly necessary in operating theatres, in out-patient departments, in renal units and in relation to the overall maintenance of equipment, and there is scope for extending the training and employment of theatre technicians and others. Their qualifications and skills are quite different from those of the nurse or midwife. We note in this connection the proposals³ of the Central Health Services Council on staffing of operating theatres to develop a group of operating department assistants.

160. We do not wish to generalise about the subject of future technological change. Whether or not aspects of treatment should be hived off from the nursing profession should depend on the extent to which they are directly related to the concept of care which is fundamental to this Report.

¹ See list of references, no. 118.

² See list of references, no. 40.

³ See list of references, no. 14.

161. Up to this point we have discussed borderlines between nurses and midwives and other professions working within the National Health Service. Nursing and midwifery work also impinges, however, on professions in other fields. We deal with the relation between nursing education and mainstream education in more detail in Chapter IV, but we note here that there is a special relationship between nurses and teachers in the field of caring for the mentally handicapped.

162. We agree with the views expressed by the Scottish Health Services Council in their report¹ on the staffing of mental deficiency hospitals, that it is neither desirable nor possible to train a substantial body of recruits to nursing in the dual role of nurse and teacher, since nursing and teaching are distinct professions, with different educational curricula and distinct skills. What is necessary is not that some new professional hybrid should be produced, but that both nurses and teachers should be recruited in sufficient numbers to carry out their different tasks and that the two professional groups should work together cooperatively and harmoniously, with mutual understanding of their complementary roles. To secure this objective, nurses, as part of their training, need to spend some time in the school noting the effect of teaching on the child. Nurses have no other role to play in the school and in no circumstances should they become aides to the teachers. While we agree that the Head Teacher is responsible for the education of mentally handicapped children, whether in the school or the hospital ward and that the Chief or Principal Nursing Officer is responsible for their nursing care, there is a need both for cooperation and freedom of movement, with the nurse able to go into the school and the teacher able to move freely in the hospital, subject to the structural authority of the Head Teacher and Chief Nursing Officer respectively.

163. Another profession with which nurses and midwives come into frequent contact is social work. Nursing and social work have distinct functions but common interests and the basis for cooperation between the two services already exists in their joint concern with aspects of care. There is, however, a lack of awareness among many nurses of the work of social workers, and this highlights the need for nurses in training, particularly those with a special interest in preventive health, to be given an understanding of the role of the social worker and vice versa. Nurses must be able to recognise when the services of the social worker are required and, particularly in the community context, they should identify problem situations, physical, mental or social, and report to the appropriate service.

164. A team approach to community care is desirable in view of the overlapping of functions between health and social service officers, but care must be taken to avoid duplication of effort. In the important fields of caring for the elderly and the physically and mentally ill or handicapped at home a multidisciplinary approach is essential in order to provide an effective overall service. Where the elderly and physically handicapped are in residential care, the social services should look to the Area Health Authority/Board to provide any nursing care required. Similarly, good collaboration is of particular importance in the care of

¹ See list of references, no. 107.

psychiatric patients, because of the overlap of function. Psychiatric hospitals should be closely linked with the family health care team and with the social services to facilitate the maintenance of the patient in community rather than hospital, and conferences on transfers should include hospital and community doctors and nurses as well as social workers.

165. We draw attention in this connection to the anxiety which was expressed to us by some bodies concerned with nursing in the community about the possible hazards resulting from the transfer of home helps to social service departments. These anxieties centred both on problems of availability and of supervision where the person attended was seriously, possibly even terminally, ill. This is an area where the maximum cooperation is essential, and where a good understanding between social service departments and community health workers must be achieved through mutual knowledge of each other's tasks and objectives.

NURSES, MIDWIVES AND VOLUNTEERS

166. In examining the relationships between nurses and others we wish finally to acknowledge that an important contribution has been and is being made to nursing and midwifery by voluntary organisations in health care. We have collected valuable evidence, much of it backed by detailed reports, from many of the bodies involved in voluntary activity, both in hospitals and in the community. Members of these bodies are often specially knowledgeable about the problems discussed in this chapter and they are able from their own experience to compare images and realities. Moreover, they contribute directly to the integration of the National Health Service. The participation of people from the local community in the running of health services not only helps to maintain or improve the quality of the services but also influences their development. It can sustain a humane and comprehensive service to patients, cutting across all the dividing lines and linking home, health centres, hostels and hospitals. Without such participation there would be far less effective and timely response to changing needs.

167. Volunteers should never be regarded as people who provide a means of diminishing the effect of staff shortages or filling gaps in the National Health Service which should properly be filled by the appointment of paid staff. Volunteer services are additional to the services of professional staff, not substitutes for them. Yet, after full consultation and within a carefully planned set of local arrangements, volunteers can contribute greatly to patient care both by relieving paid staff of some of their tasks and by providing skills and special talents of their own.

168. We are in agreement with the succinct statement of the National Association of Leagues of Hospital Friends in its evidence to us that "The use of volunteers can reduce the burden of work but not of responsibility of nurses". Although a number of the services provided by voluntary bodies may now be more appropriate to the social service departments than to the nursing and midwifery services, their value remains and will grow. Amongst the services they provide are:

- (a) visiting patients, operating trolley shops and canteens, entertaining long stay patients (who are in particular need of contact with the outside

world) and providing many other services, some of them new and experimental services, in hospital wards and departments;

- (b) providing auxiliary home nursing assistance to the local health services and providing non-nursing care for invalids in their homes;
- (c) assisting at clinics and blood transfusion centres;
- (d) escorting sick and disabled people.

This varied but far from comprehensive list of services indicates the very wide range covered by different organisations, not all of which provide all the services listed above.

169. The voluntary bodies providing support to the National Health Service include:

- (a) organisations associated with particular hospitals; for example, there are 906 individual Leagues of Hospital Friends affiliated to the National Association working in some 1,500 hospitals throughout England and Wales as well as some in Scotland;
- (b) organisations concerned with particular categories of patients like the National Association for Mental Health or the National Society for Mentally Handicapped Children; these bodies direct the attention of the public to patient needs, raise funds, encourage research and improve amenities and, like the Marie Curie Foundation, may be instrumental in providing services to the patients who are their concern;
- (c) organisations concerned with the development of nursing skills among the public; these include the British Red Cross Society, whose membership in 1971 included approximately three thousand registered nurses and 750 enrolled nurses, and the St. John Ambulance Association and Brigade, whose qualified nurse strength in August 1972 was made up of 1,430 registered nurses and thirty-four enrolled nurses;
- (d) organisations concerned with social welfare, including health welfare.

These may be either national or local bodies with a variety of purposes. There are also many people who help as individuals rather than as members of organisations or groups.

170. Some of these bodies are far older than the National Health Service, and, like the Queen's Institute of District Nursing, whose role has, of course, developed with time, they have played a pioneering part before the State stepped in: others have grown up more recently and are still emerging in response to specific needs in a changing society. Many provide sizeable numbers of recruits (both young and mature entrants) to professional nursing and midwifery each year: for example, the St. John Ambulance Association and Brigade told us in their evidence that they supplied about 450 recruits to the profession each year.

171. All nurses and midwives in training should learn something about the role of voluntary bodies and of volunteers as well as of the other professions with whom they work. Cooperation between nurses and midwives and volunteers is essential. One useful way of fostering this is through the appointment of paid voluntary help organisers. There are many such appointments, and their value would be even

greater in a period when integration is being extended if they could in future span both hospital and community.

172. With the development of an integrated pattern of health care, the opportunities for voluntary involvement should increase rather than decrease and in our view, properly accredited volunteers, who have undergone appropriate selection procedures and some induction training, have an invaluable part to play in complementing the work of nurses and midwives. Under the reorganised health administration, Area Health Authorities/Boards will largely be coterminous with local authorities and the voluntary organisations will have a natural base for their activities which can be directed to meet the health and social service needs of a clearly identified area.

173. The voluntary bodies will maintain the link between the past and the future, although new forms of voluntary action will become necessary as the moves towards integration proceed. Change must take place here as in the professions themselves, or what started as pioneering adventure can become vested interest.

174. The emphasis in this chapter on the need for a well-informed, highly adaptable, caring profession, supported by aides and backed by volunteers who also care, is the right emphasis, we believe, not only for the early 1970s but for the next few decades of nursing and midwifery. The public must be kept fully in the picture. Any further changes must be based on twentieth-century rather than nineteenth-century foundations. In our next two chapters we turn to crucial questions of training which must be answered now if the needs of the future are to be met.

CHAPTER III

NURSES AND MIDWIVES IN TRAINING

THE PRESENT TRAINING SYSTEM

175. We have collected a mass of evidence relating to nurses and midwives in training at the present time, much of it orally during our visits and much of it in the surveys which we commissioned. We have also examined as fully as we can details of their educational background. The recommendations about nursing and midwifery education which we make in the next chapter entail the introduction of a radically new system of professional education. The material presented in this chapter explains why we consider that such a radically new system is necessary.

176. We were not surprised that in their evidence to us different representative bodies concerned with the teaching professions turned the spotlight on conditions during the period of nurse training. Thus, the Joint Four, speaking on behalf of the Headmasters' Association, referred to "terrifying stories of untrained nurses being left in charge of wards at night" and to "long hours, poor pay and the old-fashioned attitudes of some matrons who rule with a rod of iron". Likewise, the National Association of Head Teachers stated bluntly that "neither high ideals nor long-term rewards will attract new recruits to the profession or retain them if they do wish to enter, if actual conditions are poor. The word gets around and recruitment often stands or falls by word of mouth communication between existing nurses and potential recruits." They also argued that for entrants of high academic ability there must always be enough intellectual work to stop the nursing students from feeling bored. "There is no point in raising the standards of qualifications unless the course of training is geared to the intellectual ability of the trainee."

177. Some of the general points of this kind which have been made to us by a few of our witnesses reflect an image of the situation which does not correspond with the reality we found on our visits and through our surveys; they certainly do not do justice to the variety of situations and opportunities in present-day nursing and midwifery, including opportunities for those of high intellectual ability. Moreover, the heavy emphasis on the problems rather than on the rewards of the profession is not calculated to appeal to potential young applicants.

178. In fact we know little of the applicants as distinct from the recruits to nurse and midwife training. There are no reliable figures of the numbers of applicants on an annual basis so that it is not possible to provide details of ratios of acceptances to rejections except in the case of particular training centres. We would welcome regularly issued information both on the ratios and on the quality of rejected applicants.

179. Education and training are carried out in a very large number of places in contrasting conditions and with different teaching strengths, educational methods and social amenities. There are 665 schools approved for training by the

General Nursing Council in England and Wales and sixty-two in Scotland. To these numbers must be added the various centres for the education of midwives, district nurses and health visitors, as well as the numerous places in which different kinds of post-basic courses are held. Numbers of basic training centres have fallen in recent years as a result of national pressures, and the process has been speeded up with the implementation of the Salmon Report and subsequent grouping of schools, but the total educational resources in terms of manpower and equipment are thinly spread. There are also marked variations in tutor/learner ratios, and there are still some schools with too few students to make the best use of educational resources. Others by contrast have too many students for the clinical experience available.

180. The teaching centres have different wastage rates, and it is possible to compare analytically those of their characteristics which influence their educational effectiveness. There are differences, for example, both amongst different types of hospital (hospitals training students for the general and sick children's parts of the register have lower wastage rates on average than do hospitals training students for the mental and mental subnormality parts of the register) and between individual hospitals of the same type. There are also differences between teaching and non-teaching hospitals.

181. In general, according to the study¹ *Threshold to Nursing* by Dr. MacGuire, differential results in examinations and drop-out rates of schools are not wholly explicable by reference to the educational composition of the intake. Moreover, bright students do less well in some schools than in others, pointing to the influence on the final outcome of training of the school as well as the characteristics of the students. Those training schools are most successful where the first few months are regarded as a trial period, during which careful attention is paid to each individual student's suitability for further training, as shown in reports from tutors and ward sisters.

182. The General Nursing Councils and the Central Midwives Boards superintend the operation of the national system of teaching institutions, insofar as it can be called a system, working, in the case of the former, with the assistance of Area (Regional in Scotland) Nurse-Training Committees. The Councils and Boards lay down syllabuses of training, inspect and approve hospitals as nurse or midwife training schools, conduct examinations and enter the names of those who have successfully completed a course of training on the register or the roll as appropriate.

183. Neither the content of professional education in nursing and midwifery nor methods of teaching can be considered in isolation. There have been so many changes in the approach to learning (what is being learned and how it is being learned) in schools and in institutions of higher education during recent years that all agencies responsible for professional education have had to concern themselves actively with (a) their access to suitable entrants and their power to attract them (b) adjusting their approach in the light of the altered motivations of students (c) the length of professional courses (d) the sequence of what is being taught within subjects or in the curriculum as a whole (e) the relationship

¹ See list of references, no. 67.

between what is being taught and future professional roles (f) innovation in teaching methods (g) the form of examinations (h) the nature of qualifications (i) refresher and continuing education.

184. We note that against this background there have been substantial moves towards change in education for the nursing and midwifery professions in recent years. Signs of change have been evident for some time; among the milestones we pick out are the experimental scheme of nurse training beginning in 1956 at the Glasgow Royal Infirmary¹, the publication of the Platt Report² *A Reform of Nursing Education* by the Royal College of Nursing (1966), the memorandum³ HM(67)58 by the then Ministry of Health on the training of nurses and the report⁴ of the Nurse Tutor Working Party (1970) set up jointly by the then Ministry of Health, the General Nursing Council for England and Wales and the Royal College of Nursing.

185. The following examples of change have been of particular interest to us:

- (a) more experimental schemes designed to test new approaches to teaching and learning and to vary the lengths of training;
- (b) the development of Colleges of Nursing, particularly in Scotland;
- (c) changes in curricula with stress on a more comprehensive education and with more emphasis on community care as an element in basic training;
- (d) attempts to relate theoretical and practical work more closely, for example through concurrent teaching programmes and the setting aside of recognised study days;
- (e) the establishment in recent years of a number of undergraduate nursing programmes in Great Britain.

186. The professional education of nurses and midwives is not unique in the fact that it includes both a practical and a theoretical element, with practical instruction being provided mainly in wards, hospital departments and community services and with theoretical instruction usually being provided in classrooms and laboratories. The teaching profession itself has a similar educational base.

187. Yet the nursing profession has distinctive features. It has two "portals" of entry, and from the start often sharp distinctions are drawn. Courses for the register normally take up at least three years; courses for the roll normally take up at least two years. There are entrance tests for the former (a minimum of two O level passes or a special entrance test), but none for the latter, suitability for nursing being assessed by interviews. The minimum age of entry for the register and roll is specified nationally, though there are variations between England and Wales on the one hand and Scotland on the other. In the former, candidates for the register and the roll have to be at least eighteen years old; in Scotland seventeen and a half. Finally there is a bigger theoretical element in training for the register than for the roll.

¹ See list of references, no. 110.

² See list of references, no. 104.

³ See list of references, no. 77.

⁴ See list of references, no. 38.

188. Although enrolment and registration are distinct qualifications, leading to very different career prospects within the profession, the actual level of work assigned to some enrolled nurses is often very similar to that assigned to some registered nurses in the staff nurse grade. We believe this can only lead to confusion and bitterness, and the proposals we put forward in Chapters II, IV and V are aimed in part at obviating this problem.

189. To complete the picture, specialisation often starts very early within the profession. The registers, for example, are divided into different parts—general, sick children’s, mental and mental subnormality (in Scotland mental deficiency) nursing—and in England and Wales (not Scotland) the roll is also divided in the same way, except that there is no sick children’s part of the roll. It is possible to become a midwife in England and Wales (but not in Scotland) without having carried out previous nurse training. There are also specialised entries into ophthalmic, orthopaedic and thoracic nursing.

190. Education for community nursing does not follow one single pattern. Not all district nurses hold a district nursing qualification at present, though increasing numbers, now about seventy per cent, do so. District nurse training can be either a post-basic course or form part of basic training, the former predominating, and can be undertaken by both enrolled and registered nurses. Courses are organised on the basis of a single national syllabus and national examinations are held three times a year. The preparation of the syllabus, approval of training centres and the examination system for courses provided by local authorities is for the time being supervised by a national Panel of Assessors appointed by the Secretary of State.

TABLE 6

NUMBER OF STUDENTS (REGISTERED) SUCCESSFULLY COMPLETING THE DISTRICT NURSE TRAINING COURSE

<i>Year</i>	<i>England and Wales</i>	<i>Scotland</i>
1966	653	119
1967	645	118
1968	756	86
1969	933	63
1970	968	141
1971	1,084	165

Source: DHSS, SHHD and WO.

In England and Wales, though not in Scotland, virtually all health visitors are qualified. Health visitor courses last for one year and student health visitors must be registered nurses and have received prescribed obstetric or midwifery training. Their education is controlled for the United Kingdom by the statutory Council for the Education and Training of Health Visitors.

CHARACTERISTICS OF ENTRANTS

191. In surveying this wide field we have examined (i) considerations affecting the age of entry (ii) current attitudes towards early specialisation (iii) the effect of the central distinction between register and roll educationally and clinically

and (iv) the needs of manpower planning. We have also collected some information about the characteristics of entrants:

- (a) fifty-three per cent of present student nurses and thirty-four per cent of pupil nurses entered the profession at the age of eighteen or nineteen years; thirteen per cent and ten per cent respectively just under the age of eighteen. A large number of bodies giving evidence to us recommended that the age of entry, subject to safeguards, should be lowered to seventeen;
- (b) twenty per cent of the student nurses and seventeen per cent of the pupil nurses in our survey said they had taken a pre-nursing course. Twenty-two per cent and fourteen per cent respectively said they had been nursing cadets. No precise figures are available about the number of students attending pre-nursing courses but there are about seven thousand cadets in hospitals in England and Wales;
- (c) given the awkward time gap between leaving school and entering nursing, it is not surprising that sixty-six per cent of all hospital nurses and midwives in our survey had a job before they started nursing. In other words, when they started their nursing education they had an initial point of reference other than school. Twenty per cent of the pupil nurses had worked in a shop, as had fifteen per cent of the student nurses. Only four per cent of hospital nurses and midwives had been shorthand typists or in secretarial jobs. Psychiatric nurses, who had entered the nursing profession later in life, had been in a variety of jobs with a relatively high proportion of manual workers among them (twenty-nine per cent). Only in the case of pupil nurses (fourteen per cent) had more than eleven per cent had job experience directly related to nursing and midwifery. To many entrants the period before entering a training school was simply an uncreative period of marking time.

192. The appeal of nursing seems usually to be generalised and undifferentiated, and knowledge of entrants about particular types of nursing seems as vague as knowledge of career opportunities. The "decision to nurse" is not always bound up with the decision to work with a particular type of patient. Our survey showed, however, that a notably smaller proportion of nurses in psychiatric hospitals mention the desire to work with the type of patient their hospitals cater for than do nurses in general hospitals. Given the particular problems of work in those hospitals, this lack of direct motivation can lead to disillusionment and wastage.

193. Nurses in training for the roll and enrolled nurses give mixed reasons as to why they are not training for the register, but only seventeen per cent mention as a reason "lack of qualifications". In other words the formal distinction usually drawn "objectively" between register and roll is not the one picked out by most of the nurses training for the roll. Twenty-three per cent say that they prefer a shorter training course. The distinction between two kinds of approach means even less. Only eight per cent say that they prefer "practice to theory". The Queen's Institute report¹ on enrolled nurses in the community services suggests a very similar pattern with only a minority stating that they became enrolled nurses because of preference and no single reason being given by a large majority of enrolled nurses; almost twenty-five per cent became enrolled because they could not complete registered nurse training for one reason or another.

¹ See list of references, no. 51.

194. Our survey suggests that the social background of student nurses varies markedly from that of pupil nurses and nursing assistants and auxiliaries.

TABLE 7

SOCIO-ECONOMIC GROUP OF FATHERS OF STUDENT NURSES,
PUPIL NURSES AND NURSING ASSISTANTS AND AUXILIARIES

	<i>Student nurses*</i>	<i>Pupil nurses</i>	<i>Nursing assistants and auxiliaries</i>
Weighted base:	1,345	386	1,605
	%	%	%
Professional, Managerial, Non-Manual	52	27	22
Skilled Manual	36	51	59
Semi-skilled and Unskilled	12	22	19

* Including post-registration students.

Source: Personal interview survey.

195. We were not able to collect detailed information concerning the effect of the recruitment policies followed by particular teaching institutions, or the social composition of the students whom they accepted for training for the register. Yet we note that there is evidence of greater social and educational homogeneity among intakes to particular teaching institutions than among recruits as a whole. Moreover, some institutions seem more able to tap a wider social reservoir of talent than others. We conclude that these figures may suggest some waste of nursing ability for social reasons.

196. There are some age of entry differences between different categories of nurses. Student nurses had entered the profession earlier than pupil nurses (sixty-six per cent before the age of twenty) and auxiliaries and assistants, who receive little or no individually supervised teaching, latest of all (only sixteen per cent below the age of twenty). Men tend to enter nursing later—fifty-eight per cent of them between the ages of twenty and twenty-nine, compared with fifty-two per cent of female nurses entering nursing below the age of twenty.

197. We know more about the initial school educational qualifications of candidates for the register than for the roll. Formal educational standards at entry for those on the general and sick children's parts of the register rose between 1963/64 and 1969/70 in England and Wales: the proportion with more than three O levels¹, which had been 13·6 per cent in 1963/64 rose to 58·1 per cent in 1969/70. For the mental illness and mental subnormality parts of the register the "improvement" was far less marked and the respective proportions were 11·4 per cent and 24·5 per cent. A valuable study² made by the Research Unit of the General Nursing Council for England and Wales showed us that in 1970/71 most entrants to pupil nurse training in England and Wales had no formal educational qualifications from school and only eleven per cent had two or more O level passes.

In the paragraphs which follow, figures for Scotland are not given, since the system of general education is organised in a different way and comparisons are difficult and the results often misleading.

¹ Grade One CSE and O level pass at A level counted as O level pass.
² See list of references, no. 43.

198. Given the increase in the proportion of pupil nurses to student nurses in England and Wales from thirteen per cent in 1962 to forty-two per cent in 1970 we have considered realistically the relationship of O level performance to entry. The table which follows sets out the effects on entry of different specified O level qualifications. Thus if in 1970/71 the minimum requirement for entry to a scheme of training had been formally set at two O level passes, twenty-eight per cent of the student nurse intake in England and Wales would not have been admitted:

TABLE 8

EFFECT ON NUMBERS OF ENTRANTS TO NURSE TRAINING IN ENGLAND AND WALES IN 1970/71 OF REQUIRING STATED NUMBERS OF PASSES AT GCE O LEVEL

<i>Number of passes required</i>	<i>Percentage of entrants to nurse training who would have been admitted</i>	
	<i>Students</i>	<i>Pupils</i>
2	% 72	% 10
3	65	7
4	54	4
5	41	3

Source: Study carried out by the General Nursing Council for England and Wales.

Only forty-five per cent of entrants to the mental illness and thirty-one per cent of entrants to the mental subnormality part of the register in England and Wales had more than two O levels in 1970/71, and for these parts of the roll in England and Wales both figures were less than six per cent.

199. Leaving on one side the question of the direct relevance to nursing and midwifery of O level qualifications at entry, there are aspects of the above table which are disquieting. The number of school-leavers with O level passes is increasing each year, and many professions other than nursing attract recruits with four or five O levels without difficulty. Yet we note that in England and Wales there were more entrants to student nurse training for the general and sick children's parts of the register with five or more O levels than with three or four. In other words, whatever the competitive pressures, a group of people continue to enter nursing who have good initial O level qualifications.

200. Some of these well-qualified entrants choose to train for the roll and not the register. Among the reasons for this may be variation between nursing schools in the entry standards they set and the acquisition by entrants of O level subjects in the right numbers but in the wrong combinations to meet particular nursing school requirements. Schools cannot always give clear reasons why they set particular O level standards or require particular combinations and we believe that too much weight can be given to formal qualifications of dubious relevance. Yet more serious reasons for the choice of the roll rather than the register seem to be, first, the shorter length of course and, second, the difficulty experienced by many lay people and even some nurses in distinguishing between the work done by an enrolled nurse and a staff nurse.

201. Given the increased numbers of boys and girls at schools who go on to take A levels, the A level figures for entrants to nursing in England and Wales are disappointingly low, particularly when it is remembered that the minimum entrance qualification for universities is two A levels. Of initial entrants to student nurse training in England and Wales in 1970/71 ninety-four per cent of the male entrants and eighty-eight per cent of the female entrants had no A levels, 2.3 per cent and 4.7 per cent respectively had two, and only 1.4 per cent and three per cent respectively more than two. Only 1,654 out of 14,195 entrants in England and Wales had any A levels. Entrants with this kind of qualification have ample opportunities to realise their full potential in a profession with varied opportunities and more clear-cut career prospects than it has had before, yet they are being attracted only in small numbers.

202. Once involved in nurse education, entrants with different initial qualifications are assembled together in different institutions which are organised on different lines. We asked nurses and midwives why they had chosen their first place of training. The answers were as follows:

TABLE 9
MAIN REASON FOR CHOOSING FIRST HOSPITAL*

	<i>Total nurses</i>	<i>Nurses and midwives in non- psych. hospitals†</i>	<i>Nurses in psych. hospitals†</i>	<i>Student nurses</i>	<i>Pupil nurses</i>
Weighted base:	7,530	6,150	1,374	1,142	388
	%	%	%	%	%
Convenient to home	24	25	22	15	25
Right kind of training	16	17	10	18	19
Good reputation	13	16	4	17	8
Knew people working there	13	10	26	11	14
Wanted work in that town	4	4	3	4	4
Wanted work away from home	2	2	1	3	2
Other positive reason	21	21	20	24	17
Other negative reason	5	4	12	5	7
Don't know	3	3	3	3	3

Source: Personal interview survey.

* Columns may not sum to 100 due to rounding.
† Distinction based on current hospital.

Nearness to home is a far more important factor than “good reputation”, and it is notable how few entrants (unlike university students) wish to be away from home.

203. A comparison of addresses of home and training centres throughout England, Scotland and Wales yielded some interesting results:
- (a) nurses and midwives currently working in London teaching hospitals came from much further afield within the United Kingdom than those in other hospitals; the pull of the London teaching hospitals is great;

- (b) nurses and midwives currently working in Metropolitan hospitals were drawn from a wider international base than those in other Regions. Indeed, thirty-four per cent of their current nursing and midwifery staff came from outside Great Britain;
- (c) nurses and midwives currently working in small hospitals (less than 250 beds) were mainly recruited locally to their first hospital training. The larger the hospital, the greater the mobility of its nurses and midwives;
- (d) nearly half of part-time nurses and midwives had lived in the same town as the hospital where they received their first training. Similarly, married and formerly married women had lower mobility;
- (e) between psychiatric and non-psychiatric hospitals there was no notable difference in mobility patterns among those recruited within this country. But the proportion coming from abroad was comparatively high (twenty-two per cent) in psychiatric hospitals. The size of this proportion may be explained on the grounds that overseas nurses are attracted to psychiatric nursing for itself or by the higher pay offered. Alternatively it could be evidence in support of the thesis that overseas nurses find it easier to get jobs in this type of hospital in view of its greater recruitment problems; overseas nurses may be more willing to go to isolated hospitals than people with roots in this country;
- (f) nurses from overseas formed a comparatively high proportion of nurses in training (twenty-two per cent of students, twenty-seven per cent of pupils). It seems likely that this indicates that a higher proportion of overseas than of indigenous nurses tend to leave the National Health Service after training, either to take other jobs in this country or to return to nurse at home.

ATTITUDES TO ASPECTS OF EDUCATION

204. We asked nursing and midwifery trainees whether as a group they would like to be treated more like students in other institutions of higher education—universities, polytechnics and colleges of education—which is the common pattern of training for local authority nursing. A small majority of student nurses (fifty-nine per cent) welcomed the idea of student status for themselves, but forty-six per cent of pupil nurses felt that it was not a good idea for themselves. Pupil nurses thought, however, that it might be a good idea for student nurses, if not themselves. There is obviously a marked feeling of status difference here.

205. The term “student status” which is often used—and has been used by a number of bodies giving evidence to us—is itself vague. Most nursing trainees feel that it means “having a students’ union”. The second most commonly held idea associated with it is that “students” would get a government grant instead of being paid a salary. The third is that students and pupils would learn theory in college, not in hospital. The fourth is that students and pupils would work in wards only to get practice; they would not help to staff them.

206. We have discussed these related ideas with students and pupils on our visits to training centres, where we have found little pressure to be assimilated with all other students. It is well known that trainees would be worse off on local education authority grants than training allowances and less well known that some students outside nursing would prefer to receive wages rather than grants.

We took all these points into account in reaching the recommendations set out in Chapter IVB, paragraphs 360–361.

207. Most trainees to whom we have talked approve of the practical element in their training. We were frequently told that nurses must train among people needing nursing skills and not in a classroom. The same point was made by most of the major training bodies which gave evidence to us. Yet we were also told and told often that the needs of the labour force take precedence over training needs and that after a few weeks of introductory work trainees are frequently despatched to wards which seem to them to have been chosen at random.

208. Another complaint is that there is little relationship between work in the ward and work in the nursing school; procedures advocated by a tutor seem to some trainees to take much longer and to be less practicable than those followed in the wards. As a result, trainee nurses may develop two standards—one for the benefit of tutors and examiners, the other for patients. Such complaints may or may not be justified in particular circumstances, and we ourselves have noted many examples of good practice: in some hospitals for instance, procedure committees representing both teaching and clinical staff agree on procedures; in others much of the instruction is provided within the context of a ward team.

209. In our survey we asked more generally for the views of recently trained and trainee nurses and midwives on the quality of teaching with which they are provided, noting that at the present time there are still large numbers of unqualified tutors (754 as against 1,648 qualified nurse tutors in England and Wales in September 1971, 146 as against 196 qualified tutors in Scotland in September 1971). The following table sets out their ratings of the different groups with whom they came into contact in training:

TABLE 10
OPINIONS OF RECENTLY TRAINED AND TRAINEE STAFF* ON
QUALITY OF TEACHING†

Rating of	Very good	Quite good	Not very good	Poor	D.K./ N.A.
Tutors	47	42	9	1	1
Doctors	35	43	11	2	9
Clinical teachers	34	34	13	4	15
Instruction from staff on wards	23	41	26	9	1
Out-of-class learning‡	61	32	4	2	2

Source: Personal interview survey.

* Recently trained staff are those who completed basic training less than five years ago.
† Percentages may not sum to 100 due to rounding.
‡ Actual question: “Which phrase would you use to describe the willingness of most tutors and instructors to help you out of class, and answer questions?”

210. It is interesting to note that there is a fairly large body of opinion which is not satisfied with the amount or quality of instruction on the wards from staff nurses and sisters. Either because there is no time (the point of view of many sisters involved in such training) or because they cannot be bothered (the point of

view of some people in training) there appears to be a tendency to give inadequate practical guidance and to demonstrate the quickest rather than the correct way of doing things. It should be added, however, that as the table shows, this is a minority opinion.

211. Looking at the scores in our survey in more detail, students tend to be more critical than pupils. We conclude that they bring to nursing education higher expectations and judge it more severely. Such critical evaluation should not be discouraged, as it sometimes is. Indeed, every attempt should be made in the teaching situation to obtain feedback from trainees. Some training schools succeed in turning the criticism into constructive channels and greatly benefit in consequence.

SIX FUNDAMENTAL PROBLEMS

212. Summing up, some of the problems arising in nursing education seem to us to be fundamental:

- (a) the ambivalent position of the nurse in training both as learner and worker;
- (b) determining the balance of theoretical and practical work in the learning process itself;
- (c) the dual role of the hospital as the provider of nursing care for patients and the provider of education for nurses;
- (d) the wide range of institutions providing education and the limited viability of many of them both as educational and social institutions;
- (e) the mix of entrants of very different academic abilities;
- (f) the timing of specialisation and elucidating the relationship between basic nursing and specialised nursing.

213. Given that theoretical and practical work must be combined and that nursing trainees must be employed on ward duties as part of their training, we asked both students and pupils and their seniors whether they believed the present balance between study and work was right. The following group of responses emerged:

TABLE 11

OPINIONS ON THE BALANCE BETWEEN STUDY AND WORK IN WARDS*

	<i>All trainees and recent trainees†</i>	<i>Registered nurses</i>	<i>Enrolled nurses</i>	<i>Student nurses</i>	<i>Pupil nurses</i>
(A) Balance between class and wards					
Weighted base:	3,027	714	566	1,142	388
	%	%	%	%	%
Too much time on wards	29	27	26	29	36
Too much time in class	5	8	5	3	3
Balance right	64	65	61	66	61
Don't know	2	—	8	2	—

	<i>All trainees and recent trainees†</i>	<i>Registered nurses</i>	<i>Enrolled nurses</i>	<i>Student nurses</i>	<i>Pupil nurses</i>
(B) Balance between learning and working in wards Weighted base:	3,027 %	714 %	566 %	1,142 %	388 %
Too much learning	—	—	—	1	—
Too much working	56	49	46	70	48
Balance right	42	51	47	28	52
Don't know	2	—	8	1	—

Source: Personal interview survey.

* Columns may not sum to 100 due to rounding.

† Includes student and pupil midwives. "Recent trainees" are staff who completed basic training less than five years ago.

In each case, the present balance was thought to tilt too far in favour of work and not far enough in favour of learning. Even recently trained registered nurses who were having to cope with the problems of short-staffing shared this view.

214. Various specific criticisms were raised during the interviews we arranged. These concerned the content of training courses and the way they are organised. We were particularly interested in probing more deeply attitudes towards the relationship between theoretical and practical work, in trainees' opinions of whether they had enough time to work on their own, whether courses covered the whole of necessary experience as trainees envisaged it, and the extent to which trainees worked together cooperatively in groups. On some of our visits we met nurses in training whose timetables were very carefully planned, who were able to digest work before being examined, and who felt that coverage was as complete as it could be.

215. We also asked in our questionnaires about the extent to which trainees were left to work independently on their own and how far at the end of the course they were satisfied about its coverage:

TABLE 12

**OPINIONS OF RECENTLY TRAINED* AND TRAINEE STAFF ON
CERTAIN ASPECTS OF TRAINING COURSES†**

	<i>Yes definitely</i>	<i>Yes, just about</i>	<i>Not at all</i>	<i>Don't know</i>
You are given enough time for studying on your own	36	34	29	1
The lectures on theory in class link up well with the practical work on the wards	38	39	22	1
You are generally given enough time on each ward to get enough experience of that type of work	58	26	16	—
All aspects of a trained nurse's work are covered by the course	39	34	24	3

Source: Personal interview survey.

* Nursing and midwifery staff who completed basic training less than five years ago.

† Percentages may not sum to 100 due to rounding.

216. As with the previous series of questions, the overall picture appears to be satisfactory, particularly in the case of the third item: obviously many nursing schools have been able to solve the most difficult teaching problems. Nevertheless, in relation to each criticism, and particularly the first, there is a substantial minority whose opinion is that the status quo is *not at all* satisfactory. The proportions confirm the impressions we formed on our visits to different teaching centres, when we were struck by the marked differences in the quality of teaching provided and in the ability of teachers to involve trainees fully in the work of the course.

217. Although the number of nurses from psychiatric hospitals answering these questions was small (only eighty-eight), it was notable that in relation to three of the four items they were much more favourable:

TABLE 13
OPINIONS OF RECENTLY TRAINED* AND TRAINEE STAFF ON
CERTAIN ASPECTS OF PSYCHIATRIC TRAINING COURSES†

	<i>Yes definitely</i>	<i>Yes, just about</i>	<i>Not at all</i>	<i>Don't know</i>
You are given enough time for studying on your own	55	30	7	8
The lectures on theory in class link up well with the practical work on the wards	37	38	17	8
You are generally given enough time on each ward to get enough experience of that type of work	69	16	12	2
All aspects of a trained nurse's work are covered by the course	52	21	17	10

Source: Personal interview survey.

* Nursing staff who completed basic training less than five years ago.

† Percentages may not sum to 100 due to rounding.

218. We also asked recently trained nurses and midwives whether they thought that, "there should be more training in managing a ward, or should that be left until after basic training is completed?"

TABLE 14
OPINIONS ON WARD MANAGEMENT TRAINING AS PART OF BASIC TRAINING*

	<i>All trainees and recent trainees†</i>	<i>Recently trained</i>		<i>Student nurses</i>	<i>Pupil nurses</i>
		<i>Registered nurses</i>	<i>Enrolled nurses</i>		
Weighted base:	3,027 %	714 %	566 %	1,142 %	388 %
More management training required	60	69	44	68	47
Management training should be left until basic training is complete	38	31	48	31	52
Don't know	2	—	8	1	2

Source: Personal interview survey.

* Columns may not sum to 100 due to rounding.

† Nursing and midwifery staff who completed basic training less than five years ago; student and pupil nurses and student and pupil midwives.

The demand for improved ward management training at an early stage is plain among students and registered nurses, to whom it is of most relevance. It is interesting also how closely each group of trainees agreed with their opposite numbers among qualified staff. The nature of our enquiry did not give scope, however, for assessing the probable variations in the understanding of what the term “management training” means. Our own view is that preparation for full participation in the team in a post of leadership should precede the taking up of such a post, and we revert to this subject in Chapter VI, paragraph 550.

219. We asked recently trained and trainee nursing and midwifery staff to sum up their impressions and to tell us which aspect of training in their view most needed improving:

TABLE 15

ONE ASPECT OF TRAINING WHICH MOST
NEEDS IMPROVING*

	<i>All trainees and recent trainees†</i>
Weighted base:	3,027
	%
The quality of teaching on the wards	32
The link between theory and practice	18
The supervision of practical work	17
The balance between learning and working	12
The time allowed for study	10
The length of training time on each ward	6
The quality of teaching in classes	4
Don't know	2

Source: Personal interview survey.

* Column does not sum to 100 due to rounding.

† Nurses and midwives who completed basic training less than five years ago, student and pupil nurses and student and pupil midwives.

220. Corresponding to evidence of other kinds which we have collected, there is a strong current of feeling that things are being improved. We asked those nurses and midwives who had trained within the past five years whether they thought each of the items above was better or worse nowadays than during their own training. Their answers follow:

TABLE 16

OPINIONS OF RECENTLY TRAINED* NURSES AND MIDWIVES ON CHANGES
IN TRAINING WITHIN THE PAST FIVE YEARS†

	<i>Better</i>	<i>Same</i>	<i>Worse</i>	<i>Don't know</i>
The quality of teaching on the wards	35	47	8	10
The link between theory and practice	32	52	4	12
The supervision of practical work	38	44	11	8
The balance between learning and working	29	53	7	12
The time allowed for study	29	56	3	12
The length of training time on each ward	22	61	7	10
The quality of teaching in classes	34	46	7	13

Source: Personal interview survey.

* Nurses and midwives who completed basic training less than five years ago.

† Percentages may not sum to 100 due to rounding.

The table suggests that while a substantial body of opinion is not concerned with drawing comparisons, there are recently trained nurses and midwives who favour present organisation and methods over those which they themselves experienced.

221. Since we were concerned about the likely effects of a number of possible future changes, some of which have been widely canvassed in recent years, we picked out two specific changes which have been suggested for the teaching of theory and asked nurses' and midwives' opinions on them.

222. The first of these involves the timing of classwork within the training period. At present, two systems predominate, the "block system" and the "study days system". The former is a system in which students go to class for three to five weeks at a time in concentrated periods, the latter is a system where students spend one to three days each week on theoretical work. A possible alternative is a "modular system" in which each module of training involves concurrent theoretical and practical work. After being given theoretical instruction, students go on to wards to practise what they have learned before they learn something else. The following table shows (a) what system the respondents followed or are at present following and (b) which, within their present knowledge, they would prefer:

TABLE 17

ACTUAL AND PREFERRED STUDY SYSTEMS

	<i>All trainees and recent trainees†</i>	<i>Recently trained</i>		<i>Student nurses</i>	<i>Pupil nurses</i>
		<i>Registered nurses</i>	<i>Enrolled nurses</i>		
A. Actual system experienced*					
Weighted base:	3,027	714	566	1,142	388
	%	%	%	%	%
Block system	67	70	34	91	36
Study days system	33	35	62	10	56
Modular system	2	2	2	1	7
Don't know	3	—	9	1	4
B. Preferred system‡					
Weighted base:	3,027	714	566	1,142	388
	%	%	%	%	%
Block system	34	39	31	33	30
Study days system	22	20	26	19	27
Modular system	41	37	36	46	43
Don't know	4	4	7	3	1

Source: Personal interview survey.

* The totals add to slightly more than 100 per cent since some nurses had experienced two kinds of system.

† Nurses and midwives who completed basic training less than five years ago.

‡ Columns may not sum to 100 due to rounding.

223. These tables do not show how actual experience relates to preference, and it is clear that the favour shown to the modular system can be based only to a very limited extent on experience of it. In Chapter IV we propose the adoption of such a system for educational reasons which seem to us to be overwhelming. We do not

suggest that the answers given in Table 17 are evidence that the system should be adopted, but we believe that they suggest that there is interest in change and willingness to accept change on these lines.

224. The second suggestion on which respondents to our survey were asked to comment was that students and pupils might be taught “pure” theory in technical colleges and the application of theory within the hospital. The idea behind the suggestion was that the trainees might benefit academically from being taught by specialists outside the hospital, and socially from mixing with non-nursing students. Reactions were as follows:

TABLE 18
REACTIONS TO SUGGESTION THAT THEORY BE LEARNT IN TECHNICAL COLLEGES*

	<i>All trainees and recent trainees†</i>	<i>Recently trained</i>		<i>Student nurses</i>	<i>Pupil nurses</i>
		<i>Registered nurses</i>	<i>Enrolled nurses</i>		
A. From a technical point of view					
Weighted base:	3,027	714	566	1,142	388
	%	%	%	%	%
The only place to learn about nursing is in hospital	75	74	75	75	78
It would be best if the theory was taught at a technical college	20	21	22	18	19
Don't know	5	5	4	7	3
B. From a personal point of view					
Weighted base:	3,027	714	566	1,142	388
	%	%	%	%	%
Would have liked to learn at a technical college along with other students	20	26	10	23	13
Prefer to learn only with other nurses	78	74	86	74	84
Don't know	2	—	5	3	2

Source: Personal interview survey.

* Columns may not sum to 100 due to rounding.
† Nurses and midwives who completed basic training less than five years ago.

It is clear that this idea (unlike modular education) did not find a great deal of favour. Again it must be remembered that trainees have on the whole little experience of technical colleges; their views on the subject can be taken only as an indication of their possible attitudes to a particular change and not as conclusive evidence of its desirability or otherwise. We set out our own conclusions on this subject in Chapter IV.

225. There are strong feelings that nurses should continue to learn nursing along with other nurses and with no-one else, and we note that even in training centres where different groups of health workers are being educated in close proximity, contact between nurses and the rest is often minimal. Only when a great effort is made by teaching staff is useful cooperation achieved.

226. Looking forward to the issues we discuss in detail in Chapter IV, if new teaching methods are to be adopted, there will have to be a more lively approach to teaching. The present shortage of teachers is aggravated by their maldistribution. The ratio of qualified tutors to student nurses varies widely, partly because of the presence in varying proportions of unqualified tutors and clinical teachers. Moreover, there is often a wide gap between classroom and ward. Few ward sisters or charge nurses have had any preparation for teaching, and many of them object that classroom teaching is not "realistic" because "things are not done in the same way as in the ward". We believe that any future pattern of learning must aim at bringing teaching and clinical staff closer together, with more interchange and a better understanding of each other's goals and problems. Clinical staff with teaching responsibilities must have adequate recognition of those responsibilities in terms of preparation, support and status. The proposals in the chapters which follow are aimed at achieving these objectives.

227. While we have noted the good relations which have been established in a number of training establishments between young and mature entrants to nursing—willingness to exchange experience and to cooperate in the natural division of labour—it is clear that the present pattern of education is not well geared to the education of large numbers of mature entrants. There are few places where the approach to work with mature entrants is differentiated and where there is real concern about which are the most appropriate educational methods to be used. A few older students can have a considerable influence on the life of a class, but they often wish to tackle problems in a different order and at a different pace.

228. We have noted relatively little widespread application of educational technology to nursing education (programmed learning, films, television): doubtless as much for reasons of cost or because of lack of the necessary technical expertise as on account of disapproval of innovations. We see considerable scope for extending the use of such methods, particularly to amplify knowledge of areas where clinical experience is limited. There are some training schools where excellent use is already made of tape recorders, videotape, overhead projectors, cassette loops and cineloop projectors, and where experiments with new methods are carefully evaluated. In a few cases there is a highly imaginative use of technical devices. The same also is true of some libraries, although we were disturbed by the evidence of the Library Advisory Council (England and Wales) that the amount of money spent on library books is extremely inadequate. This money is provided in an annual grant from the Departments allocated by the General Nursing Councils and channelled through Area (Regional in Scotland) Nurse-Training Committees to each nurse training institution. We return to these subjects in Chapter IV.

TRAINEES' WORKING CONDITIONS

229. Finally in our surveys we have collected considerable evidence from nurses in training about petty restrictions and authoritarian systems of control, some of which have already been touched on in Chapter II. Counselling systems are often unofficial, and nurses and midwives in training may be treated as initiates who have to be moulded into a system rather than as free agents who might make useful suggestions about how it could be changed:

- (a) there are sharp reactions to the arrangement of hours of work. Student and pupil nurses complain most about the lack of week-ends off;
- (b) we asked student nurses whether the following statements applied in their hospital:

TABLE 19

PERCENTAGE OF STUDENT NURSES STATING THAT VARIOUS WORKING PROBLEMS OCCUR IN THEIR HOSPITALS

	<i>Percentage of student nurses stating that problem does apply</i>
	%
There is a shortage of supporting staff	76
Too many interruptions in the middle of a task	75
Nursing is hindered by petty rules and discipline	61
Not enough supervision of junior nurses in their work	59
Nurses too busy to do all the work they have to do	59
Too many junior nurses compared with qualified ones	59
Poor administration—best use not made of nurses' time	56
Problems with doctors, nurses or patients who speak English poorly	52
Nursing is hampered by lack of proper equipment	44
Many of the nurses have not been trained well enough	42
Many nurses are just not interested in their work	40

Source: Personal interview survey.

230. On the atmosphere in educational institutions respondents are divided. Rigid discipline has few supporters amongst either students and pupils or registered nurses, but there is a clear difference of opinion between students and pupils who are overwhelmingly in favour of a “friendly atmosphere” and registered nurses who are far more cautious about the abandonment of discipline. We recognise that rules are necessary in the interests of trainees themselves, and so did most of the trainees to whom we talked, but when they are inadequately explained or involve unnecessary or arbitrary interference and control they are increasingly being questioned. There are too few good examples of joint consultative committees on which trainees are properly represented.

TABLE 20

IDEAL RELATIONSHIP BETWEEN SENIOR AND JUNIOR NURSES*

	<i>Registered nurses (includes senior staff)</i>	<i>Student and pupil nurses</i>
Weighted base:	2,589	1,530
	%	%
“The only way to run a hospital is to maintain firm discipline, with senior nurses keeping apart from juniors”	11	4
“The best way to run a hospital is if everyone is as friendly as possible”	48	81
Combination of the above	39	14
Don't know	1	1

Source: Personal interview survey.

* Columns may not sum to 100 due to rounding.

231. We note within the profession a demand for education which is not fully realised either in terms (i) of education for different posts or (ii) of continuing education:

- (a) enrolled nurses and pupils were asked, for example, whether they would like to take a further course. Of enrolled nurses, twenty-three per cent had either applied for or were seriously considering further training, while the figure for pupil nurses was fifty-one per cent. These figures indicate the willingness of a fairly high proportion of pupil nurses to consider further training, even though the avenues open to them are limited unless they take a further two years' training for the register;
- (b) a high proportion of nurses in all grades was keen to take a further training course, and among senior nurses, half of those who were "seriously considering" such a course had already made their application to start. Male nurses, whatever their grade, gave a greater consideration to further training than women. Nurses with good school examination qualifications were giving slightly more consideration to further training than those without. There was also a very slight tendency for those with higher qualifications to be keener on training courses than those with lower ones.

232. Large numbers of senior nurses in hospitals have by now taken post-basic training courses, but the provision of specialised post-certificate clinical courses in the hospital service is geographically patchy and is frequently related very directly to the need for local recruitment rather than to the provision of sound educational programmes.

233. This situation was criticised in a report¹ by the Standing Nursing Advisory Committee in 1966, *The Post-Certificate Training and Education of Nurses*, as a result of which the Joint Board of Clinical Nursing Studies was established in England and Wales to advise on the post-certificate training needs of nurses and midwives in the hospital service and to coordinate and to supervise the courses provided as a result of such advice. This Board has not yet had time to make an impact but we note that universities have no place on it and that as a result of its setting up there is one body in England and Wales responsible for pre-certificate training of nurses (the GNC) another for pre-certificate training of midwives (the CMB) and yet another for post-certificate hospital training. Although there are important links between the three bodies, and some cross-representation, there must be a risk that nurse education will not be thought of as a whole and planned as a continuous process. We also note that the Board has no remit in the field of community nursing though community nurses have recently been admitted on to two of its specialist panels. In Scotland a parallel committee has recently been set up on an interim basis but with a constitution, membership and terms of reference which obviate the points we note above.

234. In a recent report² the Joint Board advised the Secretaries of State for Social Services and Wales that there were about 350 post-registration or post-enrolment hospital courses in England and Wales alone. Some were "in-service" programmes designed to help hospital nursing staff to develop an adequate level of skill in

¹ See list of references, no. 15.

² See list of references, no. 57.

situations where they were already working. Others were educational programmes designed to prepare people to work in a new specialty. Many, however, as indicated in paragraph 232 above, were no more than devices to aid recruitment with little or no attempt to provide sound educational programmes. The need for specialised post-registration and post-enrolment programmes for nurses working in the community has not yet been generally recognised.

235. The following list provided by the Joint Board gives some examples of categories of hospital programmes which were being provided at the time of their survey in 1970. The first three of them are already nationally recognised. There is a very uneven distribution within the different parts of the country and a wide variation in educational quality and subject coverage. There is also considerable confusion of course titles:

Orthopaedic nursing

Ophthalmic nursing

Thoracic nursing

General Intensive Care including:

(a) Coronary care, renal units, recovery wards, respiratory failure

(b) Thoracic, cardiothoracic, open heart surgery

(c) Anaesthetics (if related to attendance on an anaesthetist)

Accident and Emergency

Burns and Plastic

Dermatology

Diabetes

Ear, Nose and Throat

Geriatrics

Gynaecology

Infectious Diseases

Metabolic

Neurology and Neurosurgery

Obstetrics

Occupational Health

Operating Theatre

Paediatrics

Psychiatry

Radiotherapy and Cancer

Rehabilitation

Spinal Injuries

Sterile Unit

Special Care Babies

Tropical Diseases

Urology

Venereal Diseases.

236. A number of these courses would have particular relevance for nurses working in the community. The subject matter would moreover appear to require all nurses participating in the courses to be made aware of the importance of pre-admission and post-discharge nursing care which would normally be undertaken in the community setting. Nurses working in the community are additionally

in need of specialised courses with particular relevance to their own sphere of activities, such as:

- Cardiovascular Diseases
- Chronic Sick
- Family Planning
- Genetic Counselling
- Health Education
- Screening and Early Identification, etc.

237. So far as management education is concerned, much has been achieved in recent years in England and Wales following the establishment of the National Nursing Staff Committee and the attention paid to this subject by the Local Government Training Board, although disappointingly little progress seems to have yet been made in the involvement of doctors in such training. These two bodies are also cooperating to forge links in the training of hospital and community nursing and midwifery staff as well as to promote the provision of training within their own fields. At national level, apart from some special courses for nurses and midwives to help with the introduction of Salmon and Mayston management structures, senior staff attend mixed discipline courses now run at eight university and other education centres, whilst there are to be experimental arrangements for nurses and midwives to attend courses and seminars at the Administrative Staff College, Henley, the Business Schools and the Civil Service College. At first line and middle management levels, local health authorities are expected to provide training along lines recommended by the Local Government Training Board, whilst Regional Hospital Boards, in association with Boards of Governors, are responsible for organising training programmes in accordance with advice formulated by the National Nursing Staff Committee, which has done much to foster the concept of multi-disciplinary management training in the National Health Service. Such programmes are already numerous and numbers continue to grow. Much of the training is provided within hospital service training centres, but we welcome the fact that the assistance of the education service is often sought. At present two universities, fifty-five colleges of further education (or equivalent) and fifteen polytechnics are providing facilities, whilst others provide lecturers and other support for courses at hospital centres. Because of the preponderance of nurses and midwives at first line level, courses often have to be for them alone, although at middle management level nurses and midwives are increasingly attending courses with their colleagues in other hospital professions. It is also noteworthy that at these levels training ties are developing between hospital and community services.

238. In Scotland similar developments are taking place under the auspices of the Scottish Nursing Staffs Committee. Courses for senior hospital and community nursing and midwifery staff are available at Strathclyde and Edinburgh Universities, while first line and middle management courses have been organised at four colleges and two Regional Boards have their own centres at Glasgow (using the services of lecturers from Strathclyde University) and Edinburgh. We welcome these developments and recommend that the impetus should not only be continued but increased within an integrated National Health Service. It is encouraging to note, therefore, that nurses and midwives figure prominently in the plans being

made by the Health Departments to provide courses in the management of integrated health care.

239. The position in relation to refresher courses is less satisfactory. We were told in evidence by a number of bodies, including the Society of Mental Nurses, that the present form of refresher courses does not meet the real need. Similar complaints have been made by other sections of the profession. We return to this subject in Chapter IV.

THE EDUCATION OF COMMUNITY NURSES

240. The position in relation to post-basic education in community nursing is of necessity different from that in hospital nursing. Further training is in most cases a prelude to work in the field, and there is a wide variety of refresher courses. The following pattern emerged in the community nursing profession:

TABLE 21
POST-QUALIFICATION TRAINING FOR COMMUNITY NURSES, BY GRADE

	<i>Total*</i>	<i>Senior staff</i>	<i>Health visitors</i>	<i>Home nurses</i>	<i>Domi- ciliary midwives</i>	<i>Other nursing staff</i>
Base:	2,047	70	712	844	485	408
	%	%	%	%	%	%
Health visitor certificate	35	60	94	8	12	30
District nurse certificate	35	61	25	61	38	18
SEN district certificate	4	—	—	8	1	1
First line management	2	10	2	3	2	2
Middle management	2	17	3	1	2	2
Senior management	1-	9	1	1-	1-	1-
Clinical course	1	4	1	1	1	1
Administration course	2	19	2	2	2	2
Teaching course	6	24	13	2	5	4
Aux./Asst. course	1-	—	—	1-	—	1
Other course	19	24	26	13	14	23

Source: Postal survey.

* Total in this column is less than the sum of the individual columns. This is because categories of community nurse were not discrete, and contained a certain amount of overlap.

It can be seen from the table that nearly all health visitors possess the health visitors' certificate, and that two-thirds of district nurses have one of the district nursing certificates. A fairly sizeable number of senior community nurses and midwives have also completed other courses.

241. We asked community nurse respondents to our questionnaires a similar range of questions to those put to hospital nurses. 54·6 per cent of health visitors thought that their basic courses were very good and 36·3 per cent good—a very high proportion—and the comparative figures for district nurses were 57·9 per cent and 30·7 per cent. Very large majorities of our respondents thought that the balance between theory and practice was right and that the practical instruction given was very good or quite good and directly relevant to later work. 38·5 per cent of health visitors and 25·5 per cent of district nurses thought that some important

topics had been omitted from community training and 34·4 per cent of health visitors and 40·1 per cent of district nurses agreed with the statement that there were not enough opportunities to take further training courses.

242. Surprisingly mixed reactions to post-basic training for community nurses were noted in the recent Queen's Institute report¹, more mixed than the reactions to our own questionnaires:

- (a) although a majority of medical and nursing administrators were in favour of district nurse training for both enrolled and registered nurses, there were reservations about such training being a necessary qualification for practice. In parenthesis, this was not the view of other professional bodies which gave evidence to us;
- (b) ninety-three per cent of the registered nurses who had completed a course of post-basic training found it useful (forty-eight per cent of the total number questioned said that they had acquired knowledge about the social services and thirty per cent said that they had learned about important aspects of psychology);
- (c) those registered nurses who had not taken a specific course of training for work in the community were almost equally divided about the desirability of such training;
- (d) a smaller proportion of enrolled nurses working in the community (themselves a growing part of the total community nursing work force) had been specially prepared for community work and a larger proportion of the non-trained thought training would have been helpful to them;
- (e) two hundred health visitors considered their training helpful, whereas four considered it not helpful. The remainder gave qualified answers.

243. The Society of Medical Officers of Health told us in evidence that they could see no scope for a shorter training for health visitors. The Health Visitors Association said that they would welcome a statutory requirement for health visitors to attend refresher courses similar to that applicable to midwives.

244. In the survey mentioned in paragraph 242 above community nurses were asked specifically what were their views on the advisability of one combined course to prepare "community nurses", i.e. nurses prepared to work in any or all of the three local authority nursing services. There was a wide divergence of views in the answers to this question. Some people thought district nursing and health visiting education should be combined; some considered that midwifery and health visitor training could usefully be integrated; others opted for the present pattern of specialisation. Our own views on this and other questions concerning the education of community nurses are set out in Chapter IV; in Chapter VI we relate our proposals to the expected pattern of community needs and explain why we foresee continued separate specialisation in clinical and preventive aspects of community nursing, bearing in mind that there will still be a need in some areas for the multiply qualified community nurse/midwife.

245. Although provision is made in community nursing for refresher courses, only thirty-seven per cent of enrolled nurses in community nursing had been to a refresher course as compared with fifty-seven per cent of registered nurses and

¹ See list of references, no. 51.

seventy per cent of health visitors. Just over one-fifth of the registered nurses and almost one-quarter of the health visitors had attended their last refresher course ten years ago. In a period of important social change this lag is disturbing. We note that while refresher courses for practising midwives are compulsory, such courses for district nurses and health visitors, while encouraged, are not compulsory. We also note that a majority of those attending the courses which are being given have found them helpful.

THE EDUCATION OF MIDWIVES

246. We discuss our proposals for the education of midwives in future in Chapter IV. Midwife training at present is carried out differently in England and Wales on the one hand and in Scotland on the other. In Scotland only registered and enrolled nurses are admitted to midwifery training; in England and Wales, while the majority of entrants to midwifery training are registered nurses or registered sick children's nurses (4,006 in 1970/71), there is both an intake of enrolled nurses (237) and of entrants with no previous nurse training (208). The number of people entering midwifery direct is decreasing, but both the Central Midwives Board (England and Wales) and the Royal College of Midwives told us in evidence that they wished to continue to see entry to the profession either through midwifery or nursing with conversion courses for those entering through one specialty and wishing to switch to the other.

247. The training is patient-centred and contained within a syllabus combining theoretical and practical instruction which is kept under regular review (bringing in, for example, paediatric care, with family planning being added as obstetric analgesia had been earlier).

248. In England and Wales many midwives still take a two-part course, with separate examinations for each part; but the trend is now towards a single integrated course with one final examination. In Scotland a single period training course has been in operation for over three years. Refresher courses every five years are a statutory obligation and most courses are planned on a national rather than a local basis.

249. Of the midwives we questioned 59·7 per cent thought that the teaching they had been given was very good and 29·9 per cent quite good and 84·3 per cent said that the balance between theory and practice fell into these two same categories. Only 28·1 per cent felt that important topics had been omitted from their community training course. 59·8 per cent said that they would take a further training course if the opportunity were given them.

AUXILIARIES AND ASSISTANTS

250. Auxiliaries and assistants at present have no formal national training although they are often given in-service orientation courses, limited practical training or sometimes both. In such cases it is directly related to the needs of the particular hospital or group concerned. The duration of courses varies strikingly, and half of auxiliaries and assistants have been given no training at all:

TRAINING RECEIVED BY NURSING
AUXILIARIES AND ASSISTANTS

	<i>Nursing auxiliaries and assistants</i>
Weighted base:	1,605
Induction training only	25
Later training only	15
Both	9
Neither	50
Don't know	1

Source: Personal interview survey.

In Chapter IV we give details of a survey we conducted covering the training of auxiliaries, assistants and ancillary staff (nursing) in the community. In our opinion survey over one-half (fifty-eight per cent) of hospital nurses agreed that there were not enough opportunities for enrolled nurses, nursing assistants and nursing auxiliaries to train for better jobs. Three-quarters of the auxiliaries and assistants affected agreed with this view, thirty-nine per cent of them strongly.

OVERSEAS TRAINEES

251. Finally, in our survey of nurse training we noted the special problems confronting overseas nurses of all grades, many of them unfamiliar at the outset both with the National Health Service and with living conditions in this country.

252. During the last few years significant changes have taken place in relation to the care of such students in universities and institutions of higher education, but until 1969 far less attention was paid to the special problems of the nursing trainees amongst them, even though they contributed one-third of all overseas students. In 1969 a conference was held in London, sponsored by the United Kingdom Council for Overseas Student Affairs, at which a committee was appointed to plan and organise effective orientation programmes. Yet there is evidence that many nursing students from overseas are not screened in their own countries, are not met at the airport when they arrive in Britain, travel by themselves to their hospitals and are expected to cope almost immediately with the same training programme as nursing students born in this country. Many of them have problems with the English language. In our next chapter, which deals with the pattern of education for the future, we make a number of practical recommendations as to how to improve this state of affairs.

CHAPTER IV

EDUCATIONAL PROCESSES AND ORGANISATION IN THE FUTURE

A. The Learning Process

PATTERNS AND OBJECTIVES

253. In considering the future educational pattern for nursing and midwifery we have had in mind a number of general considerations which we wish to state in broad terms before providing detailed argument and recommendations:

- (a) since the profession comprises a very wide range of skills and activities of varying complexity and since it appeals to persons of very different temperaments, no obstacles should be placed in the way of suitable applicants with a spectrum of initial academic qualifications from average intelligence to the highest;
- (b) some entrants will and should be introduced to nursing through pre-nursing courses which will require careful planning and organisation;
- (c) the intake must include entrants with high initial academic qualifications, including undergraduates and graduates, and the incentives must be made clear to such students in terms both of the social significance of the work they will be carrying out and of the range of career opportunities open to them;
- (d) whatever their initial qualifications and whether they wish to be concerned primarily with community or hospital care, all entrants should be provided, once they have entered the profession, with a sound basic education in nursing leading up to an initial statutory qualification. We call that qualification the Certificate in Nursing Practice;
- (e) there must be careful coordination at this stage of teaching and practical work;
- (f) during the period of basic education particular interests and aptitudes should be noted and students should be encouraged to continue their learning process by going on to specialise in particular branches of nursing or midwifery;
- (g) the initial education of midwives should not be separate from that of nurses. Already all midwives now qualifying in Scotland, and most midwives in England and Wales, have a nursing qualification. We believe that such a qualification will become increasingly important in the future. Midwifery, like nursing, calls for an understanding of normal physical and psychological processes, and an ability to recognise and act on deviations from the normal. These affect a minority of mothers and babies, but there is no clear or predictable boundary between the normal and the abnormal. Even more than nursing, midwifery crosses borderlines between hospital and community. As medical advances enable more women with conditions which once would have prevented pregnancy, to have babies; as management of the foetus and of sick new-born babies becomes more sophisticated; as the importance of parental health education comes to be better

recognised; as advanced post-basic specialisation in aspects of midwifery begins to evolve, the need becomes clearer for midwives and nurses to share the introduction to the elements common to both their professions. Our proposals for courses leading to Registration as a midwife and the acquisition of a Higher Certificate in this field take note of this need;

- (h) after the Certificate stage, nursing and midwifery education should continue to be regarded as a continuing process of learning and a pattern of further courses should be made readily available;
- (i) there should be a "mainstream" post-Certificate course leading to Registration. In the interests both of nurses and patients both the Certificate in Nursing Practice and Registration should have statutory recognition;
- (j) there should also be a Higher Certificate in Nursing Practice designed to attract a limited number of post-Certificate nurses with an academic bent. Work for this Higher Certificate could be carried out at the same time as work leading to Registration;
- (k) these courses would be followed and supplemented by a variety of post-Registration courses. The scope, content and range of these courses should be directly related to the scope, content and range of pre-Registration courses;
- (l) nurses and midwives should be given the opportunity through them to broaden their education as well as to deepen it. Thereby they will enhance the standard of care given to patients;
- (m) it is the individual ability of nurses and midwives to pursue successfully this pattern of professional education—and not initial academic qualifications on entry—which should determine their contribution to and prospects in nursing and midwifery;
- (n) from the point of entry onwards there should be the maximum scope for all entrants, whatever their initial qualifications, to develop their attainments in the field of general education and to follow their professional education to that level for which they are suited and wish to proceed;
- (o) each step in career development should be dependent on attaining through education and through experience the level of professional knowledge and skill required at that stage for the responsibility to be undertaken;
- (p) we emphasise that formal qualifications are important not in themselves but as evidence of development within the profession. The theoretical and practical are only two aspects of professional education. The cultivation of qualities of personality must be a part of the learning process itself. Maturity, responsibility, insight, tolerance and the ability to cope with stress in oneself and in others cannot be learned just by watching or listening. Both nurses and midwives have to deal with situations and reactions which are individual, often unexpected, sometimes sudden and catastrophic, and which require a flexible and far from routine response;
- (q) the provision of courses of further training should take account of employment needs and prospects, but selection of individuals for courses should not be based solely on service needs in particular places;
- (r) the emphasis throughout this continuing learning process should be placed on comprehensive patient care. We should move away from the situation where individual nurses or midwives who are trained in the physical aspects of caring are often left to discover for themselves the psychological needs

of the patient along with the relevant social information, for example about family relationships;

- (s) for this reason in itself more stress should be laid upon community nursing throughout the whole sequence of nursing education, including the basic Certificate in Nursing Practice course. We recognise also that the integration of the National Health Service will demand nurses and midwives who understand the logic of integration;
- (t) any introduction to "management training" should be planned within this framework, with the main emphasis being placed on quality of care, on human relationships, on communication, on team work and on partnership with others.

254. The new pattern of education that we propose will enable nurses or midwives to develop their potential to the full at their own pace. More important, it will prepare nurses and midwives who, because they have both a basic knowledge of the many skills and techniques required in comprehensive patient care and a specialised knowledge of their particular chosen field, are able to provide a uniformly high standard of care.

255. To ensure that the planning and control of nursing and midwifery education are effective and that proper thought is given to future as well as to current needs, we recommend:

- (a) the setting up of a Central Nursing and Midwifery Council for Great Britain with three Nursing and Midwifery Education Boards for England, Scotland and Wales. The Council and the Boards would be responsible for clinical nursing and midwifery education in the hospital and community settings, pre- and post-Registration;
- (b) the creation of Area Committees for Nursing and Midwifery Education, coterminous with the new Area Health Authorities/Boards, (see Chapter VII, paragraph 640 *et seq.*);
- (c) the foundation of Colleges of Nursing and Midwifery throughout the country, financed through the Area Committees.

256. We have deliberately chosen not to describe in detail all aspects of our proposed new pattern, since we believe, first, that the new statutory authorities which we are recommending should be free, along with Colleges of Nursing and Midwifery, to frame their own answers to a number of practical and theoretical questions and second because we do not wish to imply that any particular pattern of courses should be considered as final. Time should be allowed for experiments to be tested, and while change should not be embarked upon for the sake of change, there should always be willingness to review and to rearrange, provided that the objectives of professional education are clearly understood.

257. The pattern we are proposing has the definite objectives in view which are set out above, and it is in essentials more simple than the pattern in existence at present. Yet we recognise that if it is to be introduced it will involve as a matter of urgency both the provision of more teachers of nurses and midwives and an improvement in their quality. In saying this, we do not wish to decry the excellence of many existing teachers. We wish rather to ensure, first, that all are brought

towards the standards of the best and, second, that those teachers who are now unqualified should have the opportunity to undertake relevant further studies.

258. As we argued in Chapter I, paragraph 49, teachers of nurses and midwives should be aware of developments in educational techniques outside the profession, and in the interests both of teachers and of students, there should be links, wherever appropriate, between professional education and other branches of education.

THE POINT OF ENTRY

259. Turning to the point of entry into the profession and emphasising that it will be necessary to recruit from applicants with different initial academic qualifications, ranging from average intelligence to the highest, we stress the following points:

- (a) we believe not only that the number of academically demanding university courses in nursing and midwifery should increase but that there must be a flow of entrants direct from schools into nursing and midwifery with completed sixth form experience or its equivalent and with similar academic qualifications to those of university entrants. For entrants with high initial academic qualifications, those universities which offer courses in nursing and midwifery will employ their own criteria for entry;
- (b) the number of graduates is likely to remain a small, but an increasing, proportion of the profession (between two per cent and five per cent), and courses should continue to be designed to accommodate entrants to the profession with university degrees outside nursing. Similarly, university courses should be provided for those aspiring to obtain degrees with nursing content;
- (c) the profession will also need access to a larger number of entrants who on the basis of present educational qualifications have at least four O level passes or their equivalent. We conclude from projections¹ of the Department of Education and Science that it is likely that there will be a sharp fall between 1972 and 1982 in the number of girls (and boys) leaving school with no O levels or their equivalent (55.4 (56.1) per cent of total female (male) school-leavers in 1971/72 to 41.3 (42.2) per cent in 1981/82) and that the number of girls (boys) with five O levels or more or their equivalent will rise from 24.0 (23.6) per cent of total female (male) school-leavers in 1971/72 to 34.5 (33.8) per cent in 1981/82;
- (d) we believe that the Higher Certificate will appeal to substantial numbers of these entrants and to those with A levels. We emphasise, however, that training for this or for any other qualification within the profession would depend not on initial academic qualifications at entry but upon performance achieved during the course of nursing education;
- (e) as is the case with so many other careers, the relationship between secondary school performance and success in nursing and midwifery is still uncertain. While, therefore, we wish to draw attention to the need to attract candidates who have "done well" at school, we believe that nursing often appeals

¹ These projections of the numbers of school-leavers were provided by the Department of Education and Science before being published elsewhere.

strongly to late developers and to people with average intelligence or more who, though they may have few formal academic qualifications, have a high degree of motivation. Suitability should not be determined by O levels alone. We know less about how to identify "motivation" than we know about how to measure "academic ability", and we recommend that the Central Nursing and Midwifery Council, the foundation of which we are proposing, should promote and encourage further research on selection procedures involving a battery of aptitude and motivation tests;

- (f) in the meantime, selection procedures at the point of entry should include:
- (i) a scrutiny of school performance and other related records;
 - (ii) a consideration of the applicant's special interests bearing in mind service to other people and ability to establish personal relationships;
 - (iii) a study of the reports of referees based on headings provided by the nursing authorities;
 - (iv) a planned interview in which consideration would be given to all aspects of the applicant's qualifications relevant to nursing;
 - (v) evidence provided by standard tests of intelligence, such as Raven's Progressive Matrices, or the use of some acceptable indicator of ability such as a series of basic scholastic tests;
- (g) for the success of our educational proposals it is essential that each College of Nursing and Midwifery should recruit students with a wide range of abilities and that service staff as well as educational staff should be involved in the recruitment and selection processes.

260. We believe that it is essential that schools and the youth employment service should be fully informed of the new proposals for nursing and midwifery education and kept up to date about their implementation and development. At present, knowledge is patchy, particularly about the variety of openings in nursing and midwifery for young people of a very wide range of abilities, and there is some misunderstanding of the needs of the profession, particularly for entrants of academic promise and of the opportunities open to them. Arrangements for much closer liaison between schools and the youth employment service and Colleges of Nursing and Midwifery must be developed. Youth employment officers and careers masters and mistresses as well as other teachers will be better able to judge the personal qualities required in the profession from seeing the National Health Service at work than from being given lists of such qualities, and we have been impressed by arrangements made in some places whereby careers masters and mistresses and headmasters and headmistresses have been able to attend conferences and to take part in study tours. There is scope also for arranging visits both during school hours and at weekends for would-be entrants themselves, showing how entry to nursing opens a gateway to many different destinations within the profession. The raising of the school leaving age offers scope for a "job sampling" approach to nursing as well as other callings.

261. We believe that there should be an increase in the number and range of pre-nursing courses for possible young entrants and that they should be more evenly spread throughout the country. Not all present courses involve the close collaboration between school or college, hospital and community which we regard as indispensable. There is advantage to be gained also, we consider, in

seeking to relate nursing to the health and social services as a whole, possibly through courses on the lines of that provided at Filton Technical College, for young people interested in a range of opportunities open to them within the National Health Service and other caring professions. Narrow initial specialisation can be stultifying. There should be the minimum duplication of work to be done at a later stage, and attention should be paid both to general education and, when required, to the provision of O and A level courses.

262. Technical colleges, colleges of further education and sixth form colleges or their equivalent in very large comprehensive schools are suitable centres for such courses, the success of which depends on stimulating teaching, sensible relations with health institutions and social service departments, and wise guidance to individuals about career prospects. Curricula and teaching methods should not be standardised, although the Nursing and Midwifery Education Boards should prepare specimen outline syllabuses and there should be discussions between the Boards, the Education Departments, Area Health Authorities/Boards and the local education authorities before courses are established. During these discussions the division of responsibility between local Colleges of Nursing and Midwifery and the local education authorities must be defined. The possibility of awarding an Ordinary National Certificate or similar qualification has been suggested to us and we think its acceptability should be investigated by the new statutory authorities and the Education Departments.

263. The present nursing cadet schemes, which are very popular in some parts of the country, should continue in their present form for some years to come. They supply considerable numbers of recruits to the profession. Yet we recommend that in future they should be known as Preparation for Nursing Courses, and be added to the variety of pre-nursing courses. They should, in our view, remain practical in their approach, and students on these courses should continue to receive a small allowance and to have two days' release per week without abatement of pay in order to broaden their education. Their duties should be planned to enable them to receive a personal knowledge of the overall work of the hospital and, if possible, of community establishments.

264. Responsibility for the planning and management of the work of this category of students should lie jointly with the Principal of the College of Nursing and Midwifery and with the nurse administrators responsible for hospital and community services and such other agencies as may be involved, including colleges of further education.

265. It would be unrealistic to expect most young entrants to nursing to have followed such courses. Nor do we see the need to provide them in the same light as some of the bodies who gave evidence to us—simply as a means of bridging the time gap between leaving school and starting nursing. We consider that they have both educational and social value in themselves in bringing together teenagers who are interested in contributing to the health and social services in a practical way.

266. We believe that the time has come to reduce the age of entry to the nursing profession to seventeen. Most of the bodies giving evidence to us, including the General Nursing Council for England and Wales, the Royal College of

Nursing, the Department of Health and Social Security and the Welsh Office, told us they would support or would not dissent from lowering the age of entry to nurse training from eighteen, subject to appropriate safeguards. It is of course already seventeen and a half in Scotland. When average ages of marriage and first motherhood are falling, there is no need to spell out the advantages of earlier qualification, with the opportunity for longer practice before a break for family commitments. Strong arguments have often been made in the past for reducing the time gap between leaving school and beginning professional studies, both to maintain continuity of the educational process and to avoid diversion of enthusiasm into other channels. The gap will be shortened now as a result of the raising of the school leaving age to sixteen. While we recognise the unique responsibilities placed on the young nursing student, we do not believe that there are any longer convincing arguments against lowering the age of entry to seventeen on the grounds of the immaturity of the recruit, physical or psychological.

267. Unique responsibilities may, and often do, lie equally heavy on nursing students of an older age group. Yet we feel it essential to insist that a lowering of the minimum age of entry must be accompanied by positive measures to ensure that young students are not exploited as “pairs of hands”. Arrangements for counselling and occupational health provision are necessary on this and other grounds, and we make specific recommendations on this subject in Chapter VI. Night duty should be part of the student’s curriculum only for its educational value and not in order to maintain staffing levels. Students should not do any night duty during their first six months of training. Not more than five weeks of any module of education should be spent on night duty. No period of night duty should be longer than ten hours inclusive of breaks. No un-Certificated nursing student should be left in charge or physically alone except during meal breaks in a ward at night. A qualified nurse should always be readily available. During night duty, as at weekends, there must be proper support in the clinical learning situation by teachers and senior staff. Overtime is always undesirable for students and should never be regarded as normal, even though it is recognised that it may be necessary in an emergency. Hours of study should be guaranteed.

268. We feel that it is necessary to be precise about all these points. We have noted, as we pointed out in Chapter III, paragraph 176, that one of the reasons why some school teachers do not recommend nursing as a career is that they are concerned about the conditions in which their ex-pupils study and work immediately after they enter their training period for the profession. We have also taken account of the forthright remarks of nursing trainees themselves.

THE BASIC COURSE FOR THE CERTIFICATE

269. Would-be nursing students would apply to a College of Nursing and Midwifery for a place on a course for the Certificate in Nursing Practice. The prospectus of each College would give details of the location of such courses and the variety of different kinds of nursing experience available in different settings to students admitted. We wish to see an annual national publication on the lines of the *Schools of Nursing Directory*¹ issued by the King Edward’s Hospital Fund for London: it should set out all relevant details to help applicants to choose intelligently.

¹ See list of references, no. 100.

270. Once students have been accepted, we believe that there are great advantages both from an educational and from a social point of view in initiating all of them to the profession through the medium of one basic course. This course would contain a common core of clinical experience but there would be scope for limited options. Within the framework of the course students should be able to develop their theoretical knowledge according to their ability. We have tried to outline the shortest possible course which will produce a safe and confident practical nurse. The basic qualification for all students at the end of such a course, whatever their qualifications at entry, will be a Certificate in Nursing Practice. The objectives of all courses leading up to the acquisition of this Certificate should be:

- (a) to provide experience and related teaching in the basic nursing skills;
- (b) to provide experience and related teaching in the nursing of patients with physical, mental and behavioural disorders, in the nursing of patients of different age groups and levels of dependency and, of equal importance, in the nursing of patients in both hospital and community settings.

271. Basic nursing skills can be learnt thoroughly, we believe, only in clinical practice. A considerable part of the necessary preparation for the Certificate should be carried out, therefore, in a variety of clinical settings, including training in an acute general hospital (adult or children's), experience in a psychiatric service, and work with old people. Theoretical instruction should be related step by step to the relevant practical instruction. We recognise the complexities inherent in balancing work in the clinical and other settings, but stress that basic education should fit a nurse to work in any field at the basic level of membership in a nursing team.

272. All students would spend time on the study of the problems of nursing in the community, and visits, attachments and courses would be arranged. This element in education is of the utmost importance in the strategy of integration.

273. We do not believe, however, that experience in intensive care units or in areas such as convalescent wards where little nursing is required, would provide a suitable setting for pre-Certificate course work.

274. Work for the Certificate in Nursing Practice would begin with a four-week introductory course which would include:

- (a) a survey of the educational programme to be followed and an explanation of how the different elements in it are related to each other;
- (b) an introduction to the organisation, operations and forward plans of the National Health Service;
- (c) an introduction to the organisation and objectives of the social services and other supporting services in the area;
- (d) an introduction to some of the main problems of social change, with particular reference to health, disease, medicine and the place of nursing in the caring professions;
- (e) an introduction to human growth, development and reproduction in their physical and psychological aspects;
- (f) an introduction to human relations and communication;

- (g) a discussion of the role of the nurse and of professional ethics; and
- (h) an introduction to Whitley Council, consultative and grievance procedures and an explanation of the work of trade unions and professional associations.

275. Following this introductory course nursing students would pursue a programme of study and work related to a core of four twelve-week "modules". This term has been widely used in recent years, and we referred to it in Chapter III, paragraphs 222 *et seq.* We adopt it not because it is fashionable but because it is useful. We believe that the "modular" system enables the individual through the study of units of experience and related teaching gradually to build up knowledge and skills and acquire a deeper and larger understanding of the practice of nursing. Thereby it allows the greatest flexibility in programming. At the same time, in the course of its preparation, systematic analysis of the necessary components in a teaching programme is encouraged.

276. The four twelve-week modules would comprise experience in each of the four main clinical areas of medical, surgical, psychiatric and community nursing, and in each module theory and practice would be dealt with concurrently; additionally there would be at least twenty weeks' further clinical experience. Although we consider that the basic nursing skills can be learnt substantially in any of the principal settings in which nurses practise, we have chosen our four modules in such a way that the student becomes familiar with a variety of settings. We feel certain that with this experience behind them Certificated nurses will thereafter be able to perform adequately at the basic level in the nursing team in any field.

277. As far as possible, nursing students should be allowed to choose the type of experience covered in their first module. Thereafter the modules could be taken in any order according to local circumstances.

278. All students should have the equivalent of two weeks out of the twelve weeks spent on each module safeguarded exclusively for education. Determining the use and distribution of this time would be a matter for the Colleges of Nursing and Midwifery, but in every case the time set aside should provide for:

- (a) an introduction to new areas of clinical experience;
- (b) an element of continuing teaching during clinical experience;
- (c) an opportunity for the student to summarise knowledge acquired and to clarify subjects not completely understood.

279. Having completed their four core modules, nursing students would need to spend a period of time acquiring clinical experience under educational guidance in order to increase their competence and confidence up to the level required of a Certificated nurse. For able students, twenty weeks would, in our view, be a sufficient period of consolidation. This consolidation period would involve one or two "units" of clinical experience and these could be taken in any clinical setting which would provide further experience in basic nursing skills. Not more than one-third of this period should be spent on night duty.

280. In the selection of these further areas of clinical experience the following factors would be taken into account:

- (a) the student's own preference and aptitudes;
- (b) an assessment by the College of Nursing and Midwifery of the type of experience needed to ensure that the student would have been given a satisfactory balance of experience between the nursing of acute and of longer-term illness and disability and between the nursing of people in different age groups;
- (c) the kind of clinical experience actually available locally in hospital and community nursing. The Colleges of Nursing and Midwifery would list the "training units" available which would then have to be approved by the Nursing and Midwifery Education Boards.

281. The minimum period leading up to the award of the Certificate in Nursing Practice would be eighteen months, and we consider that a properly designed and efficiently implemented programme of basic education in nursing with the requisite clinical experience can be completed within this period. It will be essential for Colleges of Nursing and Midwifery to design their courses and plan their teaching in a thorough yet imaginative way. In particular, they should bear in mind from the outset that while all students will be following a common programme, they will be following it at different rates of progress and with different degrees of understanding and assimilation. Colleges should be free, therefore, to experiment with "groupings" of students, when necessary re-grouping them from one module to another in the light of students' progress. They should ensure that individual guidance is given to each student to make the best use of his or her aptitudes. Students should be told at each stage how the Certificate course is related to later work, and with the more able students it would be possible at an early stage to discuss education beyond the first Certificate and to develop a sense of perspective and involvement in the learning process. Less able students might be required to repeat one of the core modules or to lengthen the period spent on acquiring clinical experience. We stress here the importance of providing a good system of academic and personal counselling, a subject developed further in Chapter VI. Throughout the whole process of learning, students should be encouraged to work cooperatively together and be made to feel they are members of the nursing team as they will be later on as qualified nurses.

282. The programme of education for the Certificate makes no provision for the present direct entry into specialist training in ophthalmic, orthopaedic and thoracic nursing. We consider, indeed, that if the age of entry to the statutory course is reduced to seventeen the main attraction of the non-statutory courses will disappear. In reaching the decision to recommend the abandonment of these direct entry courses we have looked closely at the needs of these specialist areas of nursing. All three areas will be included in the variety of clinical settings in which nursing students may prepare for the basic qualification, and the new pattern of education will adequately prepare nurses to work in orthopaedic and thoracic teams after qualification; specialised courses in these subjects should continue to be provided for those wishing to deepen their knowledge at that stage or later. The needs of ophthalmic hospitals and units demand nursing that is either basic or highly specialised. Certificated and Registered nurses will be able to

provide the basic nursing, and the specialised nursing requirements will be met by post-basic and advanced courses.

283. One special field which we regard as particularly important is paediatric nursing. Such nursing calls for special skill, and we have been impressed by the evidence presented to us which suggests that some young people enter the profession with a particular motivation towards this kind of nursing. The same body of evidence suggests that the work of nurses caring for this age group is enhanced by some experience of obstetric and adult nursing, which assists the understanding of developmental processes, and facilitates contacts with parents.

284. In our education proposals, therefore, entrants who wish to do so could take a substantial part of the course for the Certificate in a sick children's hospital and a hospital for the mentally handicapped. Paediatric nursing would also be one of the specialised nursing subjects for the Higher Certificate, which could be taken either before or after Registration. Although, as we have pointed out in Chapter I, the numbers of children in hospital are happily less than they were in the past, a higher proportion of children in hospital are under five, more are severely disabled, and the intensity of nursing care required has grown. There will always be a role for the nurse wishing to specialise in the care of children, and we have provided for her or him in our education programme. In this field, as in others, we believe traditional boundaries will be crossed, and Registered nurses with a special interest in paediatrics as well as midwives may choose to specialise in neonatal care; others may acquire a combination of the skills now possessed by registered sick children's nurses and registered nurses for the mentally subnormal and be uniquely well prepared to care for the child handicapped in both mind and body.

REGISTRATION AND THE HIGHER CERTIFICATE

285. We recommend that students who have the ability and the desire to train further after completing their statutory Certificate in Nursing Practice would apply to proceed through the next eighteen months to Registration. We see great value in also providing during this period a more academically demanding course which would lead to the award of a Higher Certificate as well as Registration. This dual course would be particularly suitable for those nursing students who had shown above-average ability in the course for the Certificate in Nursing Practice.

286. The Colleges of Nursing and Midwifery would guide selected Certificated students either into courses leading to Registration or into a dual course. We emphasise that a good academic counselling system, necessary during the early stages of pre-Certificate training, when the new entrant is making her or his way through often unfamiliar problems, is indispensable also at this stage when important individual choices have to be made.

287. The course leading to Registration should be a coherent and meaningful educational experience both for nurses wishing to concentrate on community health and those wishing to work in hospitals. There is considerable value, in our opinion, in continuity of experience, with students proceeding immediately to post-Certificate courses in the same Colleges where they had studied and

worked for their Certificate. At the same time, the way should be open for mobility between institutions and for a postponement of going further ahead with professional education. Certificated nurses should be able to proceed at a later time in their lives to the Registration course and Registered nurses could take the Higher Certificate course later in their lives. We believe that given the continuation of present social trends the number of people wishing to acquire these qualifications later in life will increase.

288. The Registration course would include three modules of education in nursing above the level of basic skills where greater depth of study is involved. The nursing student would study two modules in the field of his or her choice and one balancing module; the balancing module for nurses interested primarily in the care of the physically ill should be a psychiatric module and vice versa. We discuss the choice of modules in more detail in paragraph 294 below. The modules would be followed by further selected units of clinical experience, and shortly before Registration all students would take part in a two-week team management course.

289. All students would have been given one module of psychiatric nursing during the course leading to the Certificate and this might have been obtained in a mental or a mental handicap setting. We think it desirable also that wherever possible those students who do not select psychiatric nursing as their field of choice in the course leading to Registration should have a balancing module of psychiatric experience. We suggest that where the pre-Certificate module was taken in a mental illness setting the balancing pre-Registration module might be in a mental handicap setting, and vice versa. Not only would this shift of settings and presumptions widen students' horizons and be a valuable nursing experience, but it would also shorten the additional length of time they would have to spend on post-Registration courses if and when they moved from one field of nursing to another.

290. Wherever experience is available an obstetric/neonatal module should be included for post-Certificate students. Paediatric experience would be obtained as a necessary part of training, as would experience of nursing elderly patients, which need not take place in specialised geriatric units. Students wishing to obtain most of their experience in sick children's hospitals or wards should be encouraged to do so when such experience is available, and hospitals for the mentally handicapped could usefully be included in the provision of this experience. The more flexible the system the better. Nevertheless, as the availability of paediatric experience will be limited, it is essential that Colleges should give priority in allocating such practical experience to those students wishing to take a Higher Certificate in paediatric nursing.

291. Although, as we explain in Chapter VI, we see the care of the mentally handicapped developing on new lines in the long run, for some years ahead it will be necessary to produce well-trained nurses to meet the needs of the mentally handicapped. The pattern of education that we have proposed will allow nurses to select nursing of the mentally handicapped as their preferred field while at the same time it will equip them better to choose in the future between continuing within the nursing profession or transferring to a new residential care profession. Students whose preferred field is nursing of the mentally handicapped will have

taken one module of mental illness or mental handicap nursing during the Certificate course and, where the experience is available, should take at least part of their medical/surgical modules in a paediatric setting. Students proceeding to Registration with a view to practising in this field will take two further psychiatric modules, of which at least one will be a module of mental handicap nursing and one will be a module of mental illness nursing if a module in this field was not taken pre-Certificate; plus one balancing general module, preferably in a paediatric setting. The units of clinical experience will be taken mainly in a mental handicap setting.

292. Students whose preferred field is community nursing will have taken one module of community nursing and have completed a period of clinical experience in this field during the Certificate course. Within the variety of different settings that we have proposed the relationship between the hospital and the community should also be studied during the other modules which form the basis of the Certificate course. Nurses proceeding to Registration in the preferred field of community nursing will have an eighteen-month programme of education designed to increase their knowledge, extend their experience and broaden their understanding of nursing in the community setting and of the interrelationship between community-based and hospital-based care. The family health sister of the future will take a Higher Certificate in her subject as her qualification to practise independently at field level. As in the case of other specialties, the course leading to this Higher Certificate may be taken simultaneously with that leading to Registration or subsequently. We recognise the value of the present post-registration course for the Health Visitors' Certificate, but we consider that our proposed programme of education, involving Registration, together with the qualification of a Higher Certificate in community preventive nursing, will more closely meet the needs of the family health sister of the future. On the clinical side the new programme leading to Registration, with the opportunity of simultaneously taking a Higher Certificate in community clinical nursing, will similarly prepare nurses better able to meet the new and developing needs of the community as family clinical sisters.

293. A period of three years from original entry to the nursing profession to Registration is essential for compatibility with present draft EEC requirements for general nurses; and for compatibility with further present draft EEC requirements Registered nurses in this field must have included maternity, paediatric, psychiatric and geriatric experience in their education. The Education Boards will have to ensure that all components of nursing education required by international agreements are covered in the courses leading to Registration.

294. To achieve compatibility with present draft EEC requirements as far as possible and to limit future training required in a transfer from one field to another the following post-Certificate pattern of education leading up to Registration is recommended:

- (a) for students whose preferred field is mental nursing: two psychiatric modules¹ plus one unit of clinical experience, one general module plus one unit of general or other experience;

¹ Of which one module would be taken during the Higher Certificate course if appropriate.

- (b) for students whose preferred field is general nursing: one general module plus one unit of general experience¹, one obstetric/neonatal module, one psychiatric module plus one unit of psychiatric or other experience;
- (c) for students whose preferred field is community nursing: one community module plus one unit of community experience¹, one psychiatric module, one module in a relevant hospital field (for those wishing to work in the preventive field, the module would be in the obstetric/neonatal field), plus one unit of relevant hospital experience (including casualty and emergency);
- (d) for students whose preferred field is nursing the mentally handicapped: one module² of mental nursing, one general module² in a paediatric setting, one module² of mental handicap nursing plus units of mental handicap experience.

295. As far as is practicable, the courses for Registration, with or without the Higher Certificate, would prepare a nurse to practise in any field of nursing. If individual nurses who had followed the pattern of studies suggested in paragraph 294 above wished to practise after Registration in a field of nursing (general, psychiatric or community) which had not been their primary choice, they would be required to complete a further module post-Registration in that field. It is recognised, however, that through choice or necessity students might complete their post-Certificate experience mainly or wholly in general or psychiatric nursing, and where a balancing module had not been taken they would be required to complete two additional modules before practising in the other field. It would be necessary, therefore, in each case for the Central Council to record the experience gained on the Registered nurse's certificate.

296. We recommend that the courses for the Higher Certificate should last six months. This Certificate would provide an additional qualification for the nurse. An eighteen-month course leading to the dual qualification might take the form of two Registration course modules followed by the six-month course for the Higher Certificate (which would include the third module) followed by one or two units of clinical experience.

297. The different elements in the Higher Certificate course would be studied in greater depth than subjects either in the curriculum of the Certificate in Nursing Practice or in the modules leading to Registration. They would be related both to hospital and community nursing and to the development of an integrated National Health Service. They would include:

- (a) human morphology, physiology, biochemistry and microbiology;
- (b) psychology (including child development) and an introduction to the social sciences;
- (c) nutrition;
- (d) preventive medicine and health education;
- (e) the principles of treatment including the action and uses of drugs and their administration;
- (f) the history and development of the nursing profession.

¹ Which would be taken on the Higher Certificate course if appropriate.

² Any one of these modules could be taken during the Higher Certificate course if appropriate.

298. Nursing students following the dual course or taking a Higher Certificate after Registration would also take a clinical course in *one* of the following subjects:

- (a) the nursing of medical patients;
- (b) the nursing of surgical patients;
- (c) the nursing of patients with orthopaedic and traumatic conditions;
- (d) the nursing of mentally ill patients;
- (e) the nursing of mentally handicapped patients;
- (f) residential care for the mentally handicapped (arranged in conjunction with social service departments);
- (g) the nursing of sick children;
- (h) the nursing of geriatric patients;
- (i) clinical nursing in the community;
- (j) preventive nursing in the community.

At the post-Registration stage further clinical courses could be added to this list, and a second course could be taken without repetition of the common element. All midwifery courses would also include a Higher Certificate, and we expand on this in paragraphs 304 and 305.

299. Although the initial selection for the dual course leading to the Higher Certificate and to Registration would be made by Colleges after the announcement of the results of the examinations for the Certificate in Nursing Practice, it should be possible for transfers to be made from the Registration course to the dual course at a later stage. Depending upon the stage reached, it might be necessary for the student wishing to transfer to complete an additional module or unit of clinical experience, in such cases extending the time necessary to obtain the two qualifications to perhaps three years three months.

300. We wish to stress that Registration is not the end of the story for the modern nurse and midwife or for the nurse and midwife of the future. The education of nurses and midwives is a continuous process. As we stated in Chapter I, knowledge and the social context are changing and new experience can and must be acquired beyond this stage. This approach to learning is fundamental to our proposals. The objective of education is to raise the quality of patient care. It is the quality of the education which concerns us, not the possession of more and more formal certificates.

301. In formulating our proposals for education to the standard of the Certificate and Registration we are aware that the recommended programme will create difficulties in some areas. While we do not think these difficulties are insuperable in the long term we acknowledge that during the early stages there will be problems in some parts of the country in providing, for instance, sufficient psychiatric and/or community experience. Colleges of Nursing and Midwifery will need to consider whether experience that is not available locally can be obtained further afield, and if necessary, discuss possible variations in the recommended programme with the Nursing and Midwifery Education Boards.

302. Our proposals will also make considerable demands on supporting staff, both qualified nurses and aides, and, particularly in London and the large conurbations, we can foresee great difficulties in recruiting the additional staff. We expect our proposals for the training of aides (see paragraphs 337-341) to increase their efficiency and we also consider that over a period of time hospitals in these large conurbations can develop their recruitment policies, particularly for staff able to work on a part-time basis. The problems of the manpower demands of our education proposals are looked at in more detail in Chapter VII.

MIDWIVES

303. We believe that the first eighteen months of training, leading to the basic Certificate in Nursing Practice, should be common to nurses and midwives. At that stage, those intending to Register and to practise as psychiatric nurses would move into the psychiatric field. It is desirable that, wherever possible, all other students intending to Register and to practise in the general field should take a three-month obstetric/neonatal module. They would then proceed to Registration after a total of three years in the ordinary way.

304. Those who wished to do so could after Registration study further to qualify as midwives. We think it desirable that most midwives should be recruited in this way, and we see no reason why they could not become satisfactory midwives after a further one-year course which would be based on the present integrated training and lead to Registration as a midwife and the award of a Higher Certificate.

305. Students who after Certification wished to practise midwifery without proceeding to Registration as a nurse would take an eighteen-month course comprising units of theory and related experience, which might include the obstetric/neonatal module and the two-week team management course. This would lead to Registration as a midwife and a Higher Certificate after a total of three years from the beginning of nurse training. The midwifery content of the course would be identical with that in the one-year midwifery course for Registered nurses but spread over a longer period to allow for the needs of the less experienced and possibly slower learner. If midwives qualified in this way wished later on to Register as nurses, they would need to undergo a further period of training. It would be for the Central Nursing and Midwifery Council to determine the length of such training in the light of future EEC decisions.

306. We stress that the quality of midwifery training offered under either of these two schemes would be identical. Each course would produce a fully qualified midwife. The difference would be in the level of nursing skill sought and obtained.

307. We have looked carefully at our proposals in the light of present draft EEC proposals, recognising that these are not yet final and that British views on future procedures will be taken into account. Under present draft EEC provisions dual qualification as a registered nurse and midwife can theoretically be achieved only in five years. We have considered, therefore, what would be the implications of this when we wish to ensure that the best use is made of the time from an educational point of view and that adverse manpower consequences are reduced

to a minimum. If the present draft EEC provisions are adopted the post-Registration midwifery course may have to last for two years. We think that such a course should take the form of one year's education followed by one year's practical experience, and on educational grounds we would deplore any attempt to spread the content of what at most is a one-year course over two years. It is at the level of further post-experience courses that we see scope for deeper education in aspects of midwifery.

EXAMINATIONS

308. Examinations for the Certificate in Nursing Practice and for Registration would be supervised by the Nursing and Midwifery Education Boards which would draw up panels of external assessors. The Area Committees for Nursing and Midwifery Education would draw up panels of experienced nurses and midwives and nursing and midwifery teachers to act as internal assessors. The Principal of the College would then select assessors from each of these panels.

309. We recommend that the Education Boards should make a close comparative study of assessment and examination techniques in different professions, where changes in procedures are still incomplete, and thereafter keep nursing and midwifery assessment under careful and regular review. The objectives of the assessment and examination system should be:

- (a) to promote high standards of safe nursing and midwifery practice in the interests of the patient;
- (b) to compare the performances of candidates in a similar setting: this comparison is in the interests of the individual nurse or midwife and in the long-term interests of the National Health Service;
- (c) to associate the testing situation with the learning situation in such a way that the nursing or midwifery student can gain educationally from the experience. For this reason there should not be one single point at which student practice is observed and tested. There should be repeated observations by appropriate people with clinical experience at all stages. This is of course already happening under the guidance of the General Nursing Councils.

310. On the completion of each module a formal assessment must be made. At least one of the four assessments should be set and marked by external assessors. A formal assessment would also be made during the units of clinical experience. The final assessment would consist of the College record, the collected results of the assessments of modules and units of clinical experience, the progress reports on the student by appropriate persons with clinical responsibility and the nursing or midwifery student's tutorial reports. An oral test and a written test to prove the student's ability to write a simple report would be arranged by the College. Borderline candidates might be given the option of a further "written test" on multiple choice lines. It is important that this final assessment should be broader in content than the previous assessments. It should include questions related to working with people, attitudes, roles, responsibilities of team members, ethical principles and relationships with other categories of staff. The assessment would be supervised by an external assessor.

311. We assume that the system as described above will be the operating system for most entrants to the profession. Yet we recognise the importance (a) of a limited entry, greater than at present, from universities and other institutions of higher education and (b) of providing for the special needs of mature entrants and recruits from overseas.

312. There are several reasons why universities and other institutions of higher education interest themselves in nursing and midwifery and why nurses and midwives should be interested in them. Two are outstanding:

- (a) the development of professional knowledge itself. The professional content of nursing and midwifery depends on the existence and enhancement of a body of knowledge related to its principles and practice. A substantial body of nurses and midwives who are graduates of universities or of other institutions of higher education is required for the advancement of such knowledge, not least through research (see part B, paragraphs 370 *et seq.*). In universities and other institutions of higher education nursing and midwifery should be considered in a broad context with both social and life sciences being brought to bear on its problems;
- (b) the needs of recruitment. The profession must recruit, as is emphasised in Chapter V, from people of widely different abilities and temperaments. Among them there must be people capable of initiating ideas, carrying heavy responsibilities and meeting on equal terms with opposite numbers in other professions, including the medical profession, and other walks of life. Courses in universities and in other institutions of higher education thus play an essential part in a long-term strategy for the profession.

313. We have not considered it part of our duty to outline possible university courses leading to degrees in nursing and midwifery. Indeed, we believe that this is the task of universities and of institutions of higher education working in close touch with national nursing and midwifery bodies. We are convinced also of the merits of diversity and of the need to encourage experiment. Yet we note that among the main components of university and polytechnic courses leading to a degree in nursing and midwifery some or all of the following subjects might be included:

- (a) biological sciences in relation to nursing and midwifery;
- (b) psychology (including social as well as clinical psychology);
- (c) sociology, with particular reference to changing patterns of health needs and health care;
- (d) statistics and the interpretation of research data;
- (e) epidemiology;
- (f) organisation theory and operational research as applied to the National Health Service;
- (g) education, including educational technology.

314. This list is not comprehensive and might in future include a technological component, for example in bio-engineering, a subject which has important and

relatively little studied implications for nursing in the future. Within a university and polytechnic context nursing and midwifery straddle the arts, sciences and social sciences, and could figure as one subject in a combined subjects degree or as a major subject in a degree including both specialised and general studies.

315. We would wish, whenever practicable, to see the Certificate in Nursing Practice and a shortened Higher Certificate incorporated within the university or polytechnic degree course for new entrants. This would ensure that there would not be such long courses for students of nursing linked with study for a degree that candidates would be deterred from following this route. We recommend that the Nursing and Midwifery Education Boards in discussions with the university in question would consider remission for relevant clinical experience or academic study.

316. Given the recommendation in paragraph 259 that the number of graduates in the nursing and midwifery profession increased to two to five per cent, there would have to be a sharp rise in the number of places in universities and other institutions of higher education and a substantial improvement in facilities. New departments of academic studies in nursing will have to be created, closely linked to other departments or forming part of a cluster of related groupings in a "school" and students admitted to these courses must be able to receive financial support at least as good as that for students reading other degrees. There should be no more argument about whether such courses qualify for awards than would be the case in relation to any other university courses in any subjects.

317. Since there is also scope in nursing and midwifery for graduates with initial degree qualifications in other subjects, we wish to press the Nursing and Midwifery Education Boards to study the possibilities of recruiting a substantial number of nurses immediately after graduation from degree courses in which nursing has not figured. There is evidence of growing interest amongst university students in work in the caring professions and in some branches of nursing (for example, psychiatric nursing) where recruitment of applicants with high academic qualifications has hitherto been difficult. We would hope that the Nursing and Midwifery Education Boards will study carefully how best such entrants could be dealt with by Colleges of Nursing and Midwifery. A few schools of nursing have already provided shortened professional courses for them. Appointments Boards should be made fully aware of the opportunities open to graduates in posts where creative and initiating abilities are required, including clinical specialisation, administration, teaching and research.

318. We hope also that it will be possible for more qualified nurses and midwives to go to a university or other institution of higher education as mature students, study degrees of their choice, and return to the profession. Employing authorities should be encouraged to facilitate this process. We welcome schemes in particular universities whereby it is possible for selected nurses to embark upon university courses without being compelled to take two A level examinations as a preliminary qualification. We also think that more assistance should be available to those nurses and midwives who wish to pursue post-graduate courses and we expand on this in Chapter VI, paragraph 608.

319. We consider it imperative, for reasons which we set out in Chapter V, to attract a large number of mature entrants to the profession. We believe that their problems require careful and imaginative treatment, not least the educational problems associated with embarking on formal learning later in life. While there may be advantages to both sides in young and mature students learning together, there is a need for separate arrangements in certain cases, particularly if more mature entrants are to be attracted. The principle on which courses for mature entrants should be designed is that while the course content does not require substantial alteration the arrangement of the programme and the teaching methods employed should wherever possible be adequate to meet the needs of such students.

320. Mature entrants may be divided into three groups:

- (a) people with minimal or no domestic commitments;
- (b) people with domestic commitments who may need to be taught in part-time courses; and
- (c) people with children who may require courses which will avoid school holidays.

321. We recommend three types of course:

- (a) shortened full-time courses for mature entrants without domestic responsibilities who wish to train as quickly as possible. We recommend that the Central Nursing and Midwifery Council, through its Education Boards, should consider possibilities of remission both on an individual basis and on the basis of criteria of more general application. We recognise that the short Certificate course does not lend itself to any significant reduction, and we ourselves would find it difficult to justify any remission of clinical experience. At the same time, we draw attention to the high motivation of this group of entrants, and suggest that every effort should be made to accommodate them;
- (b) part-time courses with no additional leave allowance. We have noted a number of part-time schemes for enrolment at present in operation, as well as one for registration, but consider present experience insufficient to provide a blueprint for all future courses of this kind. We would therefore like to see a number of alternative experiments tried. We recommend no specific pattern, but refer this subject also to the Central Nursing and Midwifery Council and its Education Boards. We believe that entry requirements for such courses and for all other courses for mature students should be flexible and that priority should be given to longer part-time courses with the same content as full-time courses rather than to shortened courses. We note that mature students on existing part-time schemes have achieved levels of attainment similar to those on full-time courses;
- (c) part-time courses with allowance for school holidays. Such courses will require very careful planning. The modular system must be followed in such a way that modules are completed within school terms.

Adequate nursery facilities for pre-school children may also be required, and should be provided wherever the benefits appear likely to outweigh the costs; there is already authority for such provision.

322. The location of courses for mature nursing students requires careful attention and we believe that there should be an examination of the pattern nationally as well as at Area level. While we welcome a reduction in the number of training centres on educational grounds, we recognise that some of the smallest training schools at present in existence have attracted mature entrants eager for employment. Not all the advantages lie with large-scale concentration and we would recommend the Area Committees for Nursing and Midwifery Education to take this factor into account in relation to new Colleges of Nursing and Midwifery. Attention should be paid to the ineffectualness of siting such courses in places where hospitals employ few or no part-timers; there is little point in providing courses without jobs. We believe that a number of Colleges should be designated nationally as special educational centres in a drive to secure more mature entrants to the profession and that the procedures which they follow should be carefully planned, evaluated and publicised as examples for other Colleges to follow through the statutory authorities in conjunction with the Health Departments.

IMMIGRANT NURSES

323. Another group with special needs, at least at the point of entry, is immigrant nurses. We direct attention to the vital role which they play in staffing National Health Service hospitals in a number of areas, and the valuable work done by the United Kingdom Council for Overseas Student Affairs which submitted helpful evidence to us. That evidence suggests an unsatisfactory situation which we described in Chapter III.

324. Wherever possible all nursing students recruited overseas should be effectively screened in their own country. They should be given (a) a test of intelligence (b) a written test of their knowledge of the English language and (c) an interview in order not only that adequate information should be available about them and their spoken English be assessed but that they too should have the chance of finding out more about the nursing situation in this country. Those interviewing them would form an assessment of educational ability and qualifications, of references submitted and of the interview itself.

325. We recognise that there are difficulties in organising such provisions, but believe that the Central Nursing and Midwifery Council must investigate the most effective methods of implementing this proposal.

326. Once selected, and before coming to this country, the students should be provided with information on the education programme, the hospital group, and nationally produced information on salaries, cost of living, clothing and travel. After arrival and before beginning training students should take an orientation course, the first function of which would be to welcome students. Arrangements should be made to receive students and to introduce them to other students and to the facilities of the hospital and education centre. With regard to the orientation course itself, different students will obviously have different needs. So, too, will students from different countries. Course content, therefore, we leave to local arrangement, but it should be based on a study of the hospital and its staff, the local community, social customs, the monetary system, transport and social facilities and, most important of all, a language component. There are advantages

in mixing orientation and professional work in the form of sandwich courses. The ideal length for a comprehensive sandwich course is about six weeks, and while the student was starting work, she or he could be learning in parallel about the new social environment of hospital and community. The minimum length for a non-sandwich type of course is about three weeks. Such a course should be held in the Region where the student is to live and it could most usefully be followed at a college of further education. Such three-week courses could be financed on the basis of providing board and accommodation with a small weekly sum for personal expenses. Opportunities for further sandwich courses should be offered to students at the end of these three-week courses and those students who were shown not to be proficient in the English language should receive further instruction until they had shown they were capable of following nurse education courses.

POST-REGISTRATION COURSES

327. In the educational pattern that we envisage there would be continuing in-service education for all nurses—an educational process which could be shared in part at least with other workers in the health services. This would be a normal on-going activity.

328. There should be provision for clinical refresher courses to improve the quality of care, including courses which will allow nurses to meet their colleagues from other areas of nursing and by exchanging views and discussing problems obtain a more balanced knowledge of the development of professional work.

329. We also envisage a substantial development of post-Registration courses with a practical bias, for nurses and midwives working in specialised fields in hospital or in the community or increasingly in posts which cut across these boundaries, as a necessary provision in a developing system of nursing and midwifery education which will be responsive to change and which allows for a greater measure of mobility.

330. For practical service needs employing authorities should examine the availability of such courses and select suitable candidates, drawing the attention of the members of their staff to the importance of further study. In particular we stress the importance of encouraging employing authorities to send nurses already qualified in the field of mental handicap to residential care courses.

331. We believe that in addition to these post-Registration courses and to the Higher Certificate which, as we have emphasised, can be taken *after* as well as before Registration, a wide range of academically demanding advanced courses should be available for nurses and midwives wishing to develop considerable expertise in specialised fields. A Registered nurse or midwife would not be required to hold a Higher Certificate—although most would be likely to do so, and all would have to show evidence of the necessary intellectual calibre—before proceeding to any of these advanced courses, which would in many instances lead to national diplomas or to other advanced qualifications.

332. It will be a major responsibility of the Central Nursing and Midwifery Council and the Nursing and Midwifery Education Boards to survey, coordinate and plan the strategy of this post-Registration specialised education. They must

pay attention to demand and seek to relate the pattern of courses to the development of the integrated National Health Service. In particular they will need to determine, in consultation with the Health Departments and National Health Service authorities, how many specialisations there should be, what should be covered by the various courses, how long they should be, where they should be provided and how the successful completion of specialised training should be recognised.

333. The Colleges of Nursing and Midwifery would be mainly responsible for the detailed planning and management of this wide range of courses. Specialised clinical programmes necessarily involve a large element of in-service clinical teaching, but the importance of this element in no way undermines the essential principle that nursing and midwifery education must be organised by educational institutions in close consultation with the hospital or community services in which such clinical experience will be gained, with an oversight of every stage of the educational process. There will be continued scope for some post-Registration courses to be sponsored in conjunction with national agencies, like the courses at present organised by the Royal Colleges and similar bodies.

MANAGEMENT EDUCATION

334. As far as education for management is concerned, we believe that while a managerial component can and should be introduced into all nursing and midwifery courses where it is relevant there is every advantage to be gained from not isolating nurses and midwives or the study of their professional problems from other professional groups. We are sympathetic not only towards the idea which has recently been canvassed of a Staff College concerning itself with management within the National Health Service as a whole, but towards any educational schemes enabling nurses and midwives to meet their opposite numbers in management courses designed for managers in different occupations, including business, industry and education. We recommend, therefore, both the continuance of special courses for nurses and midwives and the full participation of nurses and midwives in management courses designed for a variety of professions.

BACK-TO-NURSING AND BACK-TO-MIDWIFERY COURSES

335. We also recommend that more “back-to-nursing” and “back-to-midwifery” courses should be provided for nurses and midwives returning to the profession after a break of several years. Such short courses would introduce nurses and midwives to the latest developments and techniques in their chosen field and enable them to find their feet before returning to the work situation. We see similar value in the provision of “keep-in-touch” courses for nurses and midwives not currently practising but wishing to maintain their professional expertise, and Colleges should bear these needs in mind in planning their programmes.

AIDES

336. We believe that the education of nursing aides is a matter of considerable urgency. At present, despite the dependence of the nursing and midwifery system upon nursing auxiliaries and assistants in many parts of the country,

their education is fragmentary and there is no general regulation of provision for training.

337. We have looked at existing training provisions for nursing assistants, auxiliaries and ancillary staff (nursing) in the community. Details of 594 training courses for nursing auxiliaries—all of them in-service training schemes—have been obtained. These list the items of work that auxiliaries are expected to do. Thirteen per cent of the courses last less than ten hours and sixteen per cent over forty hours; twenty-one per cent contain orientation only and thirty-five per cent training without orientation. The proportions of auxiliaries attending such courses are limited. Only in seventy per cent of the hospitals did all auxiliaries attend the orientation courses and only in thirty per cent did they all attend training other than orientation. In most hospitals the organisation of the courses was in the hands not of the teaching division but of nursing and midwifery administration. Similar details were obtained of 218 in-service training schemes for nursing assistants. Seven per cent of the courses last less than ten hours and twenty-six per cent contain orientation only and twenty-eight per cent training without orientation. In seventy-six per cent of the hospitals all assistants attended orientation courses but in only twenty-six per cent did they all attend training other than orientation. We also obtained details of 147 training courses for ancillary staff (nursing). Six per cent lasted less than ten hours and thirty-one per cent over forty hours. Twenty-nine per cent contained orientation only and twenty per cent training without orientation. Ninety-four per cent of ancillary staff (nursing) attended an induction course and in sixty-three per cent of the courses they all received training.

338. We recommend the institution as soon as possible of a properly costed and planned scheme for the in-service training of nursing aides which will be considerably more than orientation training.

339. In our view, the greater part of this training should continue to be carried out in the ward or field situation and be of a practical rather than a theoretical character. It should be common to all aides whether employed full-time or part-time. The minimum formal training should comprise a one week's orientation course together with one half-day per fortnight or its equivalent during the first six months of service. Thereafter, one day's refresher training should be provided every six months.

340. We recommend that the Central Nursing and Midwifery Council, through its Education Boards, should draw up a nationally agreed outline syllabus, having regard to the existing syllabus for nursing assistants¹ and the guidance recently issued in Departmental papers². It would be the responsibility of the Colleges of Nursing and Midwifery, in consultation with the nursing and midwifery administration, to determine the detailed application of the programme, and of the trained staff in wards, units or community services to arrange its day-to-day implementation. A certificate should be awarded by the College on successful completion of the course.

¹ See list of references, no. 76.

² See list of references, no. 109.

341. In general we do not recommend reduction of professional Certification or Registration courses for those with experience as nursing aides, but every individual should have her or his experience scrutinised by the College; in exceptional circumstances long experience might be recognised by the College for remission of part of the clinical element in training.

B. The Learning Environment

CENTRAL AND LOCAL MACHINERY

342. For reasons which we set out fully in Chapter VII we recommend the creation of a Central Nursing and Midwifery Council for Great Britain with three Nursing and Midwifery Education Boards for England, Scotland and Wales, each reporting direct to the Central Nursing and Midwifery Council. In addition, we recommend the setting up of a statutory Standing Committee of the Council concerned with questions relating to midwifery. In Chapter VII we also outline the necessary organisational and functional relationships between Council, Boards and the Standing Committee on Midwifery.

343. These bodies will cover the whole field of nursing and midwifery education, which we believe it is essential to consider as one single field, except for management education and developments associated with it. We see no advantages in the long run in treating management questions which concern nursing and midwifery separately from other questions concerning National Health Service management.

344. It will be the duty of the Council and Boards to ensure that there is proper liaison with the Central Departments and the National Health Service authorities in order to safeguard service as well as educational interests. We see the main areas of liaison as being:

- (a) determining the criteria for entry to Colleges with a view to maintaining a balanced work force in nursing and midwifery in terms of skill levels related to patient needs;
- (b) ensuring that plans for specialised courses are related to the need for specialised skills;
- (c) keeping in view the changing needs of the service in order that advice can be issued to Colleges through Area Committees for Nursing and Midwifery Education.

345. We describe the Area Committees and their work in Chapter VII. The Committees will have boundaries coterminous with and including one or more Area Health Authorities/Boards.

COLLEGES OF NURSING AND MIDWIFERY

346. In this chapter we concern ourselves with the educational institutions where learning, teaching and research are carried out. We recommend that Colleges of Nursing and Midwifery shall be established throughout the country.

Each College would be financed on an annual basis by a grant made, after submission of estimates of expenditure and income, by an allocation from the Area Education Committee. The grant would include funds for staff salaries and equipment.

347. We envisage two hundred to three hundred such Colleges in Great Britain.

348. We recognise that the creation of two hundred to three hundred Colleges implies a sharp reduction in the number of existing training centres and that a reduction on this scale can be achieved only over a period of time. It will only be possible to take effective action if the College is regarded not as a single central unit but as a collective organisation which includes places now used for training and extends educational activities to places which are not yet involved.

349. Each College of Nursing and Midwifery should have its own governing body. We attach considerable importance to this recommendation as the status of each College as an educational institution will depend to a large extent on the status of a governing body which should be representative of a wide range of interests and which should be given responsibility and autonomy within the wider policies determined by the statutory authorities. The powers and duties of the governing bodies of Colleges of Nursing and Midwifery should be equivalent to those now well established in colleges of further education, colleges of education and other institutions for which local education authorities are responsible. For these establishments the legal status of the governing bodies is determined by an Instrument and Articles of Government which after preparation reflecting local circumstances must be submitted to and approved by the appropriate Secretary of State. It is recommended that a similar standard document be prepared for application to each College of Nursing and Midwifery.

350. In general, the Instrument and Articles of Government for each College would include:

- (a) a statement of the purpose of the College of Nursing and Midwifery;
- (b) an outline of the constitution of the governing body, which should include the Principal and representatives of:
 - nurses and midwives, including those responsible for service needs;
 - nursing and midwifery organisations;
 - medical organisations;
 - local health services;
 - local authorities;
 - educational organisations including polytechnics and universities;
 - College staff through the Academic Board or its equivalent; and
 - students through the Students' Union or its equivalent.

There should also be provision for coopted members;

- (c) sections on the powers and duties of the governing body relating to the appointment of the Principal and staff, the approval of estimates of income and expenditure for submission to and approval by the Area Education Committee and all other matters relating to the promotion of the College of Nursing and Midwifery and the fulfilment of its purpose.

351. It should be the duty of the governing body to appoint the Principal and supervise the educational programmes of the College. At the same time, it should ensure the implementation of the main policies of the national Education Boards and Area Education Committees within the particular local situation and the allocation of responsibilities between teaching and service staff in situations where both are involved. It should submit an annual report and plan to the Area Education Committee.

352. Each College should be under the direction of a Principal who would be assisted by senior lecturers, lecturers and clinical tutors, and, if the size of the College required it, by a Vice-Principal.

353. The Principal should be free also to employ as teachers people who are not qualified as nurses, and clinical specialists to lecture in specialist fields. The Principal, senior lecturers and lecturers would be based primarily in the College and the clinical tutors in the hospital or community setting. However, lecturers and senior lecturers, by joint appointment, formal clinical attachment or on an honorary basis, would visit and teach in the hospital and in the community setting and clinical tutors would teach in the College. Similar arrangements should apply in reverse, though the extent to which ward/field staff would be able to participate in the teaching of students would depend on their service commitments and the numbers of supporting staff likely to be available. It is essential, however, for the success of the arrangements we are proposing that the service staff receive full support to release them to carry out their responsibilities for the education of students as well as appropriate preparation. While the governing body of the College would evolve policies on the respective teaching responsibilities of the teaching and ward and field staff, a high degree of cooperation between governing body and employing authorities will be necessary if the educational process is to be successful. For example the service staff would need to be informed of the students' educational background in order that they could gear their teaching to meet the needs of individual students, and teaching staff would need to be kept constantly informed of new developments in the service.

354. The College would not necessarily be on one site. Not only should clinical teaching areas be regarded as an integral part of the College, but classroom or laboratory and practical work accommodation might be available on more than one site in different training centres. Clearly where it would be possible to have one set of buildings, students and staff would have the greatest possibility of contact and the freest access to common facilities, including a good working library and up-to-date equipment. Yet the modular system of teaching which we are proposing along with continuing education from the pre-Certificate to the post-Registration stage presuppose teaching in or close to the clinical situation. When new hospitals are being planned, provision is being made for education centres to be shared between different groups of staff, and these centres could serve as teaching "outposts" of the College. There could also be such "outposts" in the community outside the hospital.

355. There should be full cooperation on educational and social grounds with neighbouring technical colleges, colleges of further education, polytechnics and universities. Like other educational institutions, Colleges would provide a

learning environment, would offer education at different levels and would combine (see paragraphs 370 *et seq.*) teaching and research.

356. We emphasise that the success of a College will depend not only on the strength of its own teaching team but on widespread acknowledgement of the importance of its work. Wherever possible, therefore, ward and midwifery sisters, family health sisters, family clinical sisters, unit Nursing Officers and others should actively participate in its programmes and may be given honorary teaching status. The College should be the focal point of the educational activities of the locality in relation to nursing and midwifery. We believe that such an institution would be far more effective and would command far more influence than the existing training schools.

357. As an educational institution, the College should ensure the concentration and use of educational facilities. We regard as indispensable the raising of the standard of College libraries so that they become comparable with libraries which serve the training needs of other professions. Trained librarians should be appointed where possible. The facilities of the library should be available for use by qualified nurses and midwives and by nursing aides as well as students. Where circumstances are suitable, the resources of the College library should be combined with those provided for other professional health staff working in the hospitals and the community.

358. There should be adequate financial provision not only for books and journals but also for the other services which a library should provide, such as the loan of teaching programmes and aid with research. We believe that, above all, the library should be conceived of as an educational resource centre with facilities for collecting new materials. In this connection we note with approval the existence of an advisory group on educational technology which coordinates the activities of the Training Aids Unit and the Nurse Training Unit of the Programmed Instruction Centre for Industry. This group could make a particularly valuable contribution in the formative stages of the new scheme of education we propose.

359. College students should be encouraged to feel that they “belong” to their College from the date they join it. The College should be a social as well as an educational entity and it should be the duty of the Principal and staff to ensure this.

360. We have examined carefully questions relating to the status of College students, and after careful consideration have reached the conclusion that they should continue to be paid training allowances rather than receive student grants. We note the disadvantages of a student grant system—for instance, the parental means test and the loss of cover for superannuation and national insurance—and we have noted also that some students at present in receipt of grants in the higher educational system would themselves prefer to be paid wages.

361. We recommend, however, that training allowances should be paid out of Area Education Committee funds and not out of service funds as at present, with necessary cross-accounting being arranged to ensure that reimbursement is made for the value of service given by students as part of their courses. We

emphasise that students should not consider themselves as nor be considered as part of the ordinary labour force of the National Health Service. With such safeguards we believe that the disadvantages inherent in the present system would be overcome.

COLLEGES OF HEALTH AND OTHER ACADEMIC RELATIONSHIPS

362. In the long run there will be scope for developing groups of related educational activities. Indeed, since links between nursing education and other branches of education are important at every stage from pre-nursing courses to post-Registration courses on matters as different as, say, administration and management on the one hand, and the psychology, sociology and pathology of ageing on the other, we welcome close contact at the professional level between nurses and midwives and members of allied professions.

363. In this connection we have noted with interest recent developments in a number of places where nursing education is being carried out side by side with studies like physiotherapy, occupational therapy, radiography, orthoptics, remedial gymnastics, chiropody, dietetics, dental hygiene and so on. We recommend, therefore, that the feasibility of the setting up of a number of Colleges of Health should be carefully considered in the light of experience and of long-term planning for the future.

364. In the meantime, whenever practicable, Colleges of Nursing and Midwifery should be associated geographically with other educational activities relating to the National Health Service in centres providing a common location for education and training. All students and staff should use the same common rooms and other social facilities and could share secretarial and, where the workload justified it, bursarial services. There might be a common induction course and joint study of, for example, medico/legal and ethical problems and of professional associations and their role.

365. In programmes of nursing and midwifery education all students as part of their formal studies should learn of the work of related professions, first at the introductory stage of their studies and later on in more detail at the pre- and post-Registration phase. We hope that similar arrangements in relation to nursing and midwifery will become part of the education of other staff. Visits should be arranged and, when possible, joint discussions and case conferences. While in favourable circumstances joint lectures may be arranged, it is difficult to see how at this stage common courses for nursing and midwifery students and students in professions supplementary to medicine could be implemented. We believe that the best way of making further progress would be for the Nursing and Midwifery Education Boards to review with their opposite numbers in the other professions the possibility of common teaching in the future.

366. It has been made clear by some of the bodies presenting evidence to us that integration cannot proceed beyond a certain point unless there are far-reaching changes in what are now separated professions in relation to pre-entry requirements, age of entry, the timing of clinical practice, the length of courses and assessment and examination systems. We are aware also that the more

integration proceeds within the National Health Service, the greater the danger of integration stopping within the limits of the service.

367. In our view, as integration proceeds there must be a close association in educational schemes between nurses and social workers. Nurses and midwives as part of their education should be expected to appreciate the methods social workers use without knowing all the details of social workers' jobs. They could also profitably study certain subjects in common, including small group behaviour, the nature of stress and the widely different reactions to it, problems of youth and age, and the environmental background of the patient. For their part, social workers should have the opportunity to learn about the role of nurses and midwives.

368. We believe, too, that universities and other institutions of higher education should have opportunities to arrange courses and conferences for nurses and midwives alone or along with members of related professions in cooperation with Colleges of Nursing and Midwifery and their equivalents. They can offer special facilities in bringing people together, not least in relation to education itself. Teachers of nurses and midwives should be able under their auspices to meet teachers in other subjects or other professions.

369. In outlining these schemes for education in nursing and midwifery we have also considered the position in those special hospitals which are the responsibility of the Health Departments, and where patients are treated under conditions of special security. Training in these hospitals should not be regarded as a specialty either at basic or at post-Certificate level, although we envisage the possibility of relevant post-basic courses here as elsewhere, for example, in group psychotherapeutic techniques. We note the distinctive modes and patterns of recruitment for the special hospitals and the fact that they supply trained mental and mental subnormality nurses to the National Health Service. Nor are we proposing any special change in training institutions under the authority of the armed forces, which should follow our proposed programme of education.

RESEARCH

370. While it remains necessary to continue to emphasise the need for intelligent management in the interests both of the patient and of the nurse, we consider that it is also necessary to emphasise the need for research. We have been given ample evidence that in nursing and midwifery education insufficient attention is paid to research as a continuing activity. Nor is there enough emphasis on research as a prelude to innovation. Nursing should become a research-based profession. While, as in other professions, the active pursuit of serious research must be limited to a minority within the profession and there are benefits to be gained from a coordination of what research is being carried out, a sense of the need for research should become part of the mental equipment of every practising nurse or midwife.

371. Too little research is at present carried out by nurses or midwives themselves. There are conspicuous exceptions, but there is still much to be found out, for example, about the relationships between nurses and midwives and patients,

selective patient care, teamwork and evaluation of the effect on nurses and midwives of their own educational process. Research in these and many other fields is necessary if the profession is to shape its own future.

372. A greater measure of research-mindedness within the profession could be fostered during pre-Registration education by, for example, ensuring that every nurse and midwife can use a library adequately, by employing problem-solving and project techniques in teaching, by referring in teaching to research findings and reports, and specifically by encouraging nurses and midwives who show an interest in research procedures.

373. At a later stage in their educational process, however, it will be necessary to ensure the preparation of a number of experienced nurses and midwives to carry out research themselves through an extension of the present research fellowship schemes or in teams with other specialists. In this connection there must be close cooperation with universities which have the requisite research facilities, particularly those with nursing and midwifery programmes. Nurses and midwives should be seconded to universities and, when possible, university staff should be encouraged to associate themselves with Colleges. An increase in the number of university graduates in the nursing and midwifery profession would assist this development.

374. Direct research into clinical nursing and midwifery problems, which we regard as being of great importance, should begin in the ward itself or at field level in the community. Such research has direct and obvious implications for patient care and should be encouraged by the Colleges of Nursing and Midwifery and by the Chief Nursing Officers. Service funds should be made available for this kind of research.

375. We point out later in this chapter that research should also be a specific concern of nursing and midwifery educators. We also urge that adequate financial support should be forthcoming from both national and Area funds for research activity channelled directly through Colleges as soon as sufficient nurse and midwife educators are ready to carry out specific pieces of research. The numbers of such nurses and midwives are few at present and every encouragement should be given to them.

376. We commend the pioneering research work carried out by a few voluntary and professional organisations, the reports of which we have found very valuable to us, and we note also the support given by the Government to a few nursing research units. We have set out examples of recent research in Appendix I where we have also attempted to map out the different areas of research already being explored.

377. The conclusions of research—and in some cases the initial discussion of research schemes—have been discussed at conferences and during short courses. If research is to lead to innovation, we regard it as essential that nurses and midwives in all parts of the country should be given the opportunity of initiating and participating in such activities. The most effective research in the short run will be that which has immediate operational implications, but some long-term research is also necessary in relation, for example, to the impact of technological change on nursing and midwifery. It would be inappropriate in a chapter on

educational processes and institutions to dwell at length on the nature of the research required, but the need for a sound research base for nursing and midwifery practice and for nursing and midwifery administration emerges throughout our Report.

378. We would welcome the growth of a number of research units with a strong nursing and midwifery component sited near to patient care areas. Whenever possible these units should be associated with universities or other institutions of higher education, thereby being able to draw on expert skills in statistics and other research techniques. Such units would provide a focus for exchange of information, research education and support for individual research workers, who might have associate status with a unit and be allowed to use its facilities.

TEACHERS

379. To implement the educational schemes outlined in this chapter of our Report there will have to be a major drive for more teachers of nursing and midwifery and a new look at their education. This drive should have top priority.

380. The background is not encouraging. There has been little increase in the number of qualified nurse tutors in the hospital field since 1963. Moreover, the overall shortage is intensified by a maldistribution of qualified teaching staff. Failure to attract more nursing and midwifery teachers of quality would jeopardise the present pattern of nursing and midwifery education if it were to be perpetuated. There is also a serious shortage of clinical instructors—perhaps not surprising, as they express a relatively new concept—and their distribution, too, should be reviewed. The introduction of a new scheme of nursing and midwifery education spotlights problems which already exist and do not receive enough attention. Yet we believe that while the proposed new system increases manpower requirements in teaching, not least through the introduction of the modular system of study, it is only within this new framework that positive action can be taken effectively.

381. Within the new system we regard the following points as fundamental:

- (a) the need to sustain and develop professional education through a cadre of trained and qualified teachers fully aware of the educational responsibilities they are discharging and how they relate to the needs of patients;
- (b) a career structure offering similar opportunities to nursing and midwifery educators as to nursing and midwifery administrators;
- (c) an acknowledgement of the widespread responsibility for teaching by all trained staff in clinical situations;
- (d) greater opportunities for teaching in the clinical situation with encouragement and opportunities being given to ward sisters, family health sisters, family clinical sisters and midwives to participate to a fuller extent in teaching without leaving their posts;
- (e) direct interrelationships under the modular system of learning between teaching in the Colleges of Nursing and Midwifery and in the ward and

the community. No teacher would be entirely based in College or in the clinical situation;

(f) full use of the teaching contribution of clinical and other specialists;

(g) use, whenever possible, of teaching staff in colleges of further education and institutions of higher education.

382. To secure a greater number of recruits and to promote the education of teachers of nursing and midwifery who at present are unqualified the following conditions are essential:

(a) flexible entry requirements, particularly during the transitional period (see paragraph 397 below);

(b) easy access to part-time day release courses which will need to be carefully planned under national supervision.

383. We also wish to get completely away from what has become the traditional conception of the nurse tutor, a maid of all work required to teach all subjects in the nursing syllabus. We believe that this conception is inapplicable in present and future circumstances. It can no longer satisfy the individual concerned nor provide the right approach to teaching for students.

384. Extending a concept which is basic to this Report, we recommend that in each College of Nursing and Midwifery the teaching staff under the direction of the Principal should consider themselves and be considered by others as a teaching team. The team would include both teachers, i.e., staff employed either part-time or full-time in teaching, and staff for whom teaching would be one function among others:

(a) the teachers would include clinical tutors (filling the role of the present clinical instructors and teachers of pupil nurses) lecturers, senior lecturers and Principal with (in large colleges) a Vice-Principal;

(b) the teachers with other responsibilities would include ward and midwifery sisters, family health and family clinical sisters, unit Nursing Officers, other National Health Service staff and attached lecturers from colleges of further education or other institutions of higher education.

Some teaching would also be provided by those preparing to qualify as nurse and midwife teachers.

385. Teachers from all existing nursing and midwifery specialties would be eligible for full-time appointments to the Colleges of Nursing and Midwifery including those of Principal. We recognise that one implication of this arrangement is that nurse teaching staff at present based in general education establishments (mainly health visitor tutors) would be drawn back into the National Health Service framework. Yet given the maintenance of strong links with general education, which is central to our proposals, we consider that any weakening of outside contacts will be more than compensated by the strengthening of nurse and midwife education as an integrated whole.

386. Clinical tutors should be based within a clinical context, but they should also teach in the College. With the introduction of the modular system they

would be closely involved in concurrent teaching for each module. Obversely lecturers would be based in the College, but would be expected to play an active part in clinical teaching.

387. We would like to get away completely from the idea of separate and parallel teaching and move to the idea of a fully integrated system. Under the direction of the Principal, lecturers could be responsible for:

- (a) the teaching of nursing at a basic level;
- (b) the teaching of nursing or midwifery at a specialised level;
- (c) coordination of the educational programmes of groups of students to ensure that teaching resources and clinical experience are both efficiently utilised.

388. Senior lecturers should be based on the College but would also take part in clinical teaching. Their main responsibilities under the direction of the Principal should include:

- (a) specialist subject teaching at a higher level;
- (b) the coordination and supervision of pre-Certificate and post-Certificate courses, the clinical components of degree courses and post-Registration courses;
- (c) research.

389. In the interests of students we would also wish to see in each College a senior member of the team responsible under the Principal for ensuring that student health, welfare and counselling services exist, function and are used. Another member of the team would be primarily responsible under the Principal for coordinating with the service staff on programming and clinical allocation. In the service setting there would need to be a placement officer who, working in close cooperation with the allocation officer, would ensure that each student gains the necessary clinical experience. We recognise that the marrying of theoretical and practical experience will be an extremely complicated exercise and suggest the possibility of making use of computer facilities and expertise at regional or Area level in programming allocations. The Principal would have responsibility for all work in the College, for clinical teaching in the hospital and community settings and for the integration of hospital and community learning, and would act as senior adviser at Area level for nursing and midwifery education. The Vice-Principal grade would be regarded as offering an opportunity for lecturers or senior lecturers to acquire experience in the administration of nursing and midwifery education.

390. We recommend that every effort should be made by the Principal to attract to College teaching a wide range of staff (including non-nursing National Health Service staff and staff from outside the National Health Service altogether). While there may be some honorary teaching appointments, funds must also be made available for visiting lecturers.

391. Clinical nurses and midwives at ward and field level along with unit Nursing Officers and their opposite numbers in the community should be appointed, possibly on a sessional basis, to teach in the clinical situation and in

the College. The salary implications of such clinical teaching will have to be examined and decided upon by the Whitley Council.

392. We attach the utmost importance to the way teachers of nursing and midwifery are themselves educated. They must be given adequate preparation:

- (a) for the acquisition of professional and clinical skills;
- (b) for teaching;
- (c) for administration;
- (d) for their role in research.

393. As far as the first of these forms of preparation is concerned, the proposals set out above for post-Registration courses will allow teachers of nursing and midwifery to pursue specialised work to the highest level. While it is desirable that teachers should have the appropriate level of clinical skill before they prepare to become teachers, they could also take post-Registration clinical courses after they had obtained their teaching qualifications.

394. The basic educational qualification for full-time teachers of nursing and midwifery should be the Diploma in Nursing and Midwifery Education. All lecturers would be required to hold this diploma, whatever their subject of specialisation. The diploma course, like some courses already in existence, would last one year and would be taken on a full-time or part-time day release basis. There could be some diversity in the pattern of courses, but we would like to emphasise the importance (a) of common work bringing together nurses and midwives with different specialties (b) of the organised study of educational techniques and problems in a wider context than that of nursing and midwifery. Consideration should be given to extending the present practice of centring some of these courses on the various colleges where teachers from other disciplines are trained. We hope that some nurse graduates who intend to become teachers of nursing or midwifery will be encouraged to take a post-graduate certificate of education with other students in a university or college of education.

395. We note the recent review of the work of colleges of education and hope that if the main proposals of the James Committee¹ (1972) are put into effect:

- (a) the first two-year cycle would be planned with a view (at least in some colleges) to providing a pattern of higher education which would be suitable for people who might wish after their time there to become nurses or midwives rather than to become teachers or take up other jobs;
- (b) the Registered nurse and midwife qualifications which we are proposing should be treated (at least in some colleges) as an initial qualification permitting a Registered nurse or midwife to spend two years in a college of education engaged in acquiring a teaching certificate. We believe that colleges may in this way be able to help in the education of teachers of nurses and midwives. Within the present system registration carries with it usually no title outside the profession.

396. We recommend that, in liaison with the Education Departments, the Health Departments (through manpower and personnel units) and the Central Nursing and Midwifery Council (through its Education Boards) should plan as

¹ See list of references, no. 22.

a matter of urgency a ten-year programme to increase the number of holders of the Diploma of Nursing and Midwifery Education, first working out the numbers deemed necessary, second the numbers which it is thought practical to train and, third, supplementing existing facilities by arranging crash courses, if necessary, and designating centres where part-time as well as full-time students can be trained. Funds should be set aside nationally to ensure the success of this programme.

397. During the transitional period formal entrance requirements will have to be waived. Entrance requirements for courses should be as flexible as possible, though all candidates should be required to submit details of their *curriculum vitae* and be interviewed. The Central Nursing and Midwifery Council through its Education Boards would then lay down future minimum entrance requirements. We would hope that these would be based on the applicant's experience and performance after entering the profession and not before it and that special significance should be attached to the Higher Certificate. When the new system begins to operate we would also expect senior lecturers to hold relevant higher qualifications and/or degrees and we would consider it desirable that lecturers also should be graduates: we include, as an important group, graduates with degrees which included nursing and midwifery studies. The opening up of such career opportunities is discussed more fully in Chapter VI.

398. Apart from diploma courses, we attach importance to other courses designed to raise the quality of teaching of particular members of teaching teams, and we recommend that more practising nurses and midwives should follow City and Guilds courses or similar courses provided by other institutions. These courses could be followed on a part-time, day release or sessional basis. We hope that colleges of education, continuing education centres of universities, polytechnics and colleges of further education will experiment further with the provision of such courses.

REFRESHER TRAINING

399. Finally we wish to draw attention to the importance of refresher courses. Education is as much a continuing process for teachers as it is for practising nurses and midwives. Since 1965 the General Nursing Council for England and Wales has required nurse tutors to attend refresher courses, and in 1967 the requirement was extended to include teachers of pupil nurses. In 1970, clinical instructors were also included. In the early 1970s there will be a further extension of numbers when those tutors who participated in the courses in the late 1960s apply to attend their second course. The General Nursing Council for Scotland has required nurse tutors and clinical teachers to attend refresher courses since 1971. We believe that these courses are essential in the interests of good educational practice and that the planners of the courses should always take account of newly identified needs. We maintain that among the subjects which should always figure in such courses are teaching methods, educational management, counselling, communications and assessment and examinations.

CHAPTER V

NURSING AND MIDWIFERY RESOURCES AND THEIR UTILISATION

THE NURSING AND MIDWIFERY WORK FORCE

400. In looking ahead to the period of further integration of the National Health Service we have paid attention throughout our discussions not only to education, the subject of our last two chapters, but to basic considerations of manpower and resources. Given the distinction between long-term and short-term problems to which we directed attention in Chapter I, paragraph 4, we tried to ensure in our recommendations that we find answers to manpower problems which are directly related to the process of integration. We believe that critical questions which are at present being asked concerning "shortages" and "wastage" need to be considered with such perspectives in view.

401. The National Health Service is a very large employer of human resources. Its total work force of almost one million people is second in size only to the work force in education and, as in the case of education, the employees are widely dispersed in all parts of the country. There are, however, more distinct identifiable groups within the National Health Service than there are in education, with nurses and midwives constituting the largest single relatively homogeneous group. The word "relatively" must be inserted since, as we have already shown in Chapter II, within the group there is room for an exceptionally wide range of interests, abilities, aptitudes, responsibilities and aspirations.

402. Rates of pay, basic conditions of service and a generally applicable career structure are determined nationally within the National Health Service. Actual recruitment, however, like contracts of service and detailed conditions of employment and deployment, is very much a local responsibility. (At present there are 356 Hospital Management Committees/Boards of Management, thirty-three Boards of Governors and 228 local health authorities, and in the proposed integrated service on current expectations there will be about 103 Area Health Authorities/Boards.) In consequence, the efficiency of the nursing and midwifery work force depends upon an adequate interrelationship between national, regional and local policies.

403. We have had this interrelationship in mind throughout our enquiries—not least on our visits—and we wish to emphasise that in the future efficiency will continue to depend on the initiative and support and the financial provision of regional authorities within the system. Later in this chapter we examine in more detail the present pattern of variations both within the hospital service and the community service. Problems of regional variation will continue to arise within an integrated system.

404. A further important factor which cannot be ignored is that however much money the Government may decide to spend on the National Health Service—and there have been significant increases in real terms over the years—the funds

TABLE 23

SUMMARY OF NATIONAL HEALTH SERVICE NURSING AND MIDWIFERY STAFF AT 30 SEPTEMBER 1971

	Hospital			Community			Total hospital and community	
	England and Wales		Scotland	England and Wales		Scotland*	Great Britain	
	Whole-time equivalent	%	Whole-time equivalent	Whole-time equivalent	%	Whole-time equivalent	Whole-time equivalent	%
Total	263,452	100.0	33,938	26,183	100.0	2,835	332,408	100.0
Senior nursing staff (Salmon and Mayston Grade 7 or equivalent and above)	12,028	4.6	1,574	1,149†	4.4	244†	14,995	4.5
Other registered nursing staff	67,476	25.6	8,906	16,585‡	63.3	2,074‡	95,041	28.6
State certified midwifery staff	10,616	4.0	1,752	4,379	16.7	458	17,205	5.2
Enrolled nurses	38,520	14.6	5,167	1,828§	7.0	68	45,521	13.7
Student nurses	49,442	18.8	6,359	—	—	—	55,801	16.8
Pupil nurses	21,794	8.3	3,040	—	—	—	24,834	7.4
Pupil midwives	4,585	1.7	1,042	1,010	3.9	—	6,637	2.0
Nursing assistants, nursing auxiliaries and other nursing staff	58,991	22.4	12,098	1,232	4.7	53	72,374	21.8

* Figures relate to 31 December 1971.

† Includes administrative and supervisory staff.

‡ Includes health visitors, home nurses and others with SRN or equivalent qualification.

§ Includes home nurses and others with SEN qualification.

Source: DHSS, SHHD and WO.

available will inevitably be limited in relation to demand. Whatever the resources, there will always be unmet health needs, primarily because of rising expectations of standards of health care. The increased supply of services itself contributes to the rise in expectations. Within such a context the question of how to determine priorities must arise.

405. In this Report we do not, indeed cannot, measure the extent to which nursing and midwifery can claim additional resources in relation to competing claims: each of those claims may require the same degree of detailed scrutiny which we have devoted to nursing and midwifery. We are concerned, however, with:

- (a) the resource implications of the changes in education, career structures and conditions of work which we are proposing; indeed, we have tried at every point in examining particular proposals to assess their resource implications as a part of the exercise;
- (b) constraints on any proposals we would wish to make which might be imposed by the manpower situation locally and nationally;
- (c) ensuring that our proposals represent in total what we consider to be the most effective means of ensuring the objectives which are set out in Chapter I.

406. In making our calculations we are handicapped by reason of the following facts:

- (a) there are no adequate data relating to the overall balance between nursing and midwifery supply and demand at national level;
- (b) no satisfactory measurement of general staffing needs has yet been devised;
- (c) what attempts have been made to measure the need for nursing staff have concentrated on acute hospitals. Little effort has been made to extend the study of staffing difficulties into community nursing or those areas and sectors in hospital nursing where there seem to be the worst problems, particularly psychiatric, geriatric and long-stay hospitals. We refer to the recent Department of Health and Social Security and Welsh Office exercise on minimum staffing ratios in the fields of mental illness, mental handicap and geriatric nursing in paragraph 513;
- (d) since the very serious difficulties in nursing staffing relate largely to local pockets within the National Health Service, which we identify later in this chapter, national statistics dealing in aggregates cannot reveal the full severity of local problems;
- (e) the variations, some of them sizeable, in local staffing patterns which can be traced from any breakdown of national figures are not always easy to understand. They suggest to us that inadequate attention is paid locally to determining criteria for staffing needs and to pursuing effective personnel policies. Moreover the figures are not usually subject to regular review;
- (f) attempts to apply formulae, discussed briefly in Appendix I, are recognised as having weaknesses;
- (g) there are not only regional variations: there are variations in the same kind of hospital within the same Region which cannot be attributed to the layout of the wards, the presence of day patients or the presence or absence of centralised services. Moreover, the amount of non-nursing support is variable and is not related to the amount of nursing time. The highest-

staffed hospitals in most Regions have about one-third more staff than the least well staffed hospitals;

- (h) Chief Nursing Officers tend to think in terms of budgetary rather than of manpower ceilings and naturally, if they can, spend up to the budgetary ceiling, recruiting whatever balance of staff can be obtained;
- (i) national machinery necessary for the planning of the whole system is inadequate, although the need to plan is being increasingly recognised.

407. The handicaps listed above have limited the possible approaches we might have made to our subject. Moreover, while we have not been short of information, we have not been able to collect all the information we have required. Nursing and midwifery must be amongst the most heavily documented professions in this country, and to digest the volume of material is a formidable task. Nevertheless, the data were deficient in some important respects, and we tried to fill in some of the gaps by including a number of relevant manpower and personnel questions in the surveys mentioned in Chapter I and detailed in Appendix I. With the information ultimately at our disposal we have been able to assemble enough material to allow us to chart the recent past, to analyse the present situation and to point the way ahead, and we are making recommendations to ensure that the information flows and planning mechanisms in the integrated service will enable the situation thereafter to be kept under regular scrutiny.

RECENT TRENDS

408. We turned our attention first to a number of assumptions which feature prominently in current thinking about nursing and midwifery—that recruitment is difficult; that shortages are pervasive; that there are high rates of wastage and turnover, particularly in training; that resources made available for nursing and midwifery have grown slowly and are in constant danger of depletion. We thought it just as necessary to sort out fact from myth in relation to this range of quantitative questions as we did in relation to the qualitative questions which we discussed in Chapter II.

409. Taking hard facts, there has been a rapid growth in nursing and midwifery time available over the last ten years or so (see Chapter I, paragraph 5). The growth was not even, but there was a substantial increase of nursing and midwifery resources made available to the National Health Service between the late 1950s and the late 1960s. The increase kept pace with the growth in medical staffing, where an increasing proportion of doctors were in the training grades as the number of places in medical schools expanded. The increase in resources made available to nursing and midwifery was achieved during a period when labour market conditions were in general highly competitive; nevertheless the profession has been able to attract an increasing proportion of the nation's working population. Between 1964 and 1970, as we showed in paragraph 5 of Chapter I, the percentage rose and this trend is continuing.

410. The growth in hours worked by nurses and midwives has been made possible by changes in the balance of recruitment and in the composition of the nursing and midwifery work force. At the inception of the National Health Service most nurses—apart from male nurses in hospitals for the mentally ill and the mentally handicapped—were young single women who worked full time, and nearly all trained staff were registered nurses, certified midwives or

TABLE 24

HOSPITAL AND COMMUNITY NURSING STAFF. NUMBERS OF WHOLE-TIME AND PART-TIME STAFF 1963* AND 1971*, BY GRADE (GREAT BRITAIN)

	1963				1971		
	Whole-time staff	Part-time staff		Total whole-time equivalent †	Whole-time staff	Part-time staff	
		Number	Whole-time equivalent †			Number	Whole-time equivalent †
Hospital service	194,718	65,833	42,426	237,144	224,602	126,486	78,788
Registered nurses and certified midwives	70,359	23,681	14,607	84,966	78,043	42,121	24,309
Enrolled nurses	12,179	8,297	5,513	17,692	28,996	22,071	14,691
Student nurses and pupil midwives	68,518	—	—	68,518	61,428	—	—
Pupil nurses	9,476	128	90	9,566	23,851	1,331	983
Nursing assistants, auxiliaries and others	34,186	33,727	22,216	56,402	32,284	60,963	38,805
Community service	..	..	..	22,509	..	..	..
Registered nurses and certified midwives	..	..	..	20,323	..	..	..
Other nurses‡	..	..	..	2,186	..	..	..

Source: DHHS, SHHD and WO.

* The whole-time equivalent of hospital nursing staff in 1963 was based on an eighty-eight hour fortnight whereas in 1971 it was based on an eighty-four hour fortnight.

† See Glossary.

‡ Including enrolled nurses, pupil midwives and ancillary nursing staff in the community.

their equivalents. In 1972 the nursing and midwifery work force is drawn from a much greater variety of groups, despite the popular image of the profession still tending to reflect the position, as was suggested in Chapter II, as it was before the inception of the National Health Service. Some of the factors are illustrated in the on page 119, which shows continuing change during the 1960s.

411. The significant factors which emerge from this table are the growing popularity of the roll, the increasing contribution being made to nursing and midwifery by nursing auxiliaries and assistants and the recent growth in the employment of part-time staff. The consequent broadening of the base in the nursing and midwifery work force is to be welcomed in view of the differing levels of work to be done. Moreover, there is a closer correspondence of the base to the demographic make-up of the female population as a whole. It is important, however, that training provision, career structures, the arrangement of work and conditions of service should provide adequate flexibility to allow for optimum opportunities while maintaining or enhancing job satisfaction for individual nurses and midwives. Resource questions are as much human questions as questions relating to education and management. Our proposals elsewhere in this Report are in large measure designed to relate education and management more closely to the needs of a changing work force.

412. One of the biggest recent changes has been an increase in the participation of older women in nursing and midwifery and the return to the profession of married nurses and midwives. It is significant that our postal survey showed about twenty-seven per cent of pupil nurses are aged thirty or more as compared with six per cent of student nurses. Two-thirds of community nurses and midwives are aged forty or more, and ninety per cent are aged thirty or more. Some sixty per cent of hospital nurses and midwives (despite the inclusion of student and pupil nurses in the base figure for the calculation) and sixty-eight per cent of community nurses and midwives are married (see footnote † to Table 25). An estimate, prepared by the Office of Population Censuses and Surveys, gives the following participation rates (see footnote* to Table 25) within the National Health Service of qualified female nurses and midwives living in Great Britain:

TABLE 25
PARTICIPATION RATES* OF QUALIFIED FEMALE NURSES AND MIDWIVES, BY AGE AND MARITAL STATUS (GREAT BRITAIN)

<i>Age</i>	<i>Qualified single female nurses and midwives</i>	<i>Qualified married female nurses and midwives</i>	<i>All qualified female nurses and midwives</i>
24 and under	89	53	71
25-29	84	34	45
30-39	86	39	45
40-49	78	45	51
50-59	56	46	49
60-64	24	19	25

Source: OPCS and SCPR surveys.

* Percentage number of the population defined as currently in employment in the National Health Service as a nurse or midwife.

† Includes widowed, divorced and separated.

No similar figures are available for earlier years. It seems clear, however, that return to work has become increasingly common during the past few years.

413. Our survey figures suggest that there is a work cycle. In keeping with trends in the female labour force generally, more and more female nurses and midwives break their career at the birth of their first child, return when circumstances allow, often on a part-time basis in the first instance, and gradually increase the contribution they make to the profession as their children grow older. At present over a half of all married nurses and midwives return, in striking contradiction to casual impressions that most do not return. The rate of return is lower than that of women doctors, which was seventy-six per cent for those under sixty-five in Great Britain in 1968. It compares well, however, with that of women teachers (fifty-eight per cent in 1965)¹ even though teachers have the special advantage of working hours which are compatible with looking after children of school age. It has to be borne in mind also that a nurse or midwife who is expecting a child may well have to give up work somewhat earlier than women in many other occupations.

414. Another element in the diversity of nursing is the contribution made by male nurses. There are relatively few in the community nursing service, but in the hospital service they currently number over thirty-five thousand. The major concentration, as we have seen, is in mental illness and mental handicap hospitals where men constitute approximately one-third of the total nursing staff. As might be expected, male nurses show rather different career characteristics from their female colleagues. Few, of course, work part time. Even more significant, they tend to enter nursing somewhat later in life and are more likely to have had previous experience of other work. Once trained, however, the proportion who leave the service is lower than the corresponding figure for female nurses, largely because there is no temporary drop-out in mid-career. Thus the age distribution of male nurses is somewhat different from that of female nurses.

415. It is perhaps significant that about one-third of the Salmon Chief and top Principal Nursing Officer posts have been filled by male nurses. There are no male Directors of Nursing Services in the community nursing service, but the proposed further development of nursing in the community may be expected to provide opportunities. We do not wish to see any reduction in the numbers of women in high-grade nursing posts and we recognise that nursing as a career offers special opportunities (within the existing social system) to women, yet we recommend that a concerted effort be made to recruit more male nurses in view of the potential return on investment in training and the diversity of the contribution male nurses can make to nursing. We consider it regrettable that over recent years the number of male nurses has not risen in accord with the general growth in nursing numbers recorded earlier. Indeed, within the hospital service the number has remained fairly stable with the result that the proportion of male nurses employed has fallen from fourteen per cent in 1959 to twelve per cent in 1971.

416. The rate of growth in the nursing and midwifery work force has been achieved only with a significant contribution from immigrant nurses and midwives. To a large extent this is no doubt a reflection of the general immigration that has been taking place throughout the 1960s and the fact that for many immigrant nurses and midwives, as they freely admitted in the survey carried out by PEP (see Appendix I), the opportunity to come to Britain was as much a

¹ See list of references, no. 53.

motivating force as the desire to become a nurse or midwife. Nevertheless in 1971 some twenty-four per cent of all trainees in England and Wales were born overseas (excluding the Republic of Ireland), and more than half of these applied for and were accepted for training whilst resident overseas. The most rapid increase in the number of immigrant nurses and midwives was between 1959 and 1964 and since then the figures have levelled out. The countries of origin have changed somewhat also, with a decline in the number coming from the West Indies and Nigeria and an increasing contribution from Mauritius and Malaysia. In general we found in our postal survey that some four per cent of ward sisters (or their equivalents), seven per cent of staff nurses, eight per cent of enrolled nurses, fifteen per cent of midwives and six per cent of nursing auxiliaries/assistants in the hospital service were born in a developing country of a father also born in a developing country and arrived in this country after the age of sixteen.

WASTAGE AND TURNOVER

417. Nursing and midwifery have been able to recruit, but have they been able to retain? It could be that the profession has been more attractive to potential recruits than to people who have had some experience of it. Strong motives of idealism may draw people into the profession. Experience of pay and conditions and the scope of the job may then cause disillusionment once they have been attracted into it. The kind of disillusionment was examined in Chapter II.

418. A high wastage rate would be a significant indication of dissatisfaction during training, and often it has been assumed that wastage rates among nurses and midwives are abnormally high compared with those found in other walks of life. What is the evidence? Nurses and midwives enter the profession through different routes. For our purposes here we have selected those parts of the nursing register and roll for which the majority undertake training and we find that wastage rates in England and Wales for such trainees have been as follows. Midwives have not been included for the majority of them are already trained nurses.

TABLE 26

ANNUAL RATES OF WASTAGE OF NURSES (SELECTED GROUPS)
IN TRAINING IN ENGLAND AND WALES*†‡

	General		Mental		Mental subnormality	
	Student	Pupil	Student	Pupil	Student	Pupil
	%	%	%	%	%	%
1964/65	14.5	20.0	23.1	..	26.8	..
1965/66	11.8	20.4	19.4	18.6	21.3	33.3
1966/67	13.0	20.0	20.5	43.7	22.7	35.8
1967/68	12.7	22.6	19.0	34.4	21.9	25.1
1968/69	12.3	19.8	18.5	25.0	19.1	21.9
1969/70	11.3	19.2	17.0	23.8	18.0	12.9
1970/71	10.0	18.2	14.1	17.8	16.7	17.8

Source: Annual Report of the GNC for England and Wales.

* Calculated from figures published annually in the Report of the General Nursing Council for England and Wales. Table shows number of nurses who discontinued training in the year as a percentage of the average number of nurses in training during the year. Years are from 1 April to 31 March.

† Figures for students are annual rates of wastage from three-year courses. For pupils figures are annual rates of wastage from two-year courses.

‡ A proportion of those who discontinue later return to training.

Statistical information available for Scotland cannot be provided on a comparable basis but the pattern appears to be similar:

TABLE 27

PERCENTAGE NUMBER OF ANNUAL INTAKE TO NURSE
TRAINING DISCONTINUING TRAINING IN SUBSEQUENT YEARS
IN SCOTLAND

<i>Year of Intake</i>	<i>Students</i>	<i>Pupils</i>
	%	%
1964	31·3	..
1965	30·9	..
1966	29·7	32·8
1967	32·3	31·6
1968	24·2	35·1
1969	31·6	30·9
1970	25·7	32·4
1971	11·5	16·4

Source: General Nursing Council for Scotland.

419. Total wastage from an average intake of student nurses is about thirty-three per cent over three years. Wastage is heaviest in the first year of training, and it is also higher among pupils and those outside general nursing. These rates of wastage are higher than those for trainee teachers and for students in higher education. Yet they are somewhat lower than the turnover rates found among young women at work. We have been struck by the power of the pressures on the trainee nurse, and some wastage is easy to understand, given the highly demanding work and the profound and often unpredictable stresses associated with it.

420. We do not view the position with complacency. Clearly wastage could be reduced by better initial selection, by wide personal counselling, by improving working conditions and above all by raising the quality and quantity of training. Wastage rates will not fall generally so long as nursing and midwifery trainees are thought of as employed nurses or midwives carrying out a few hours of study each week.

421. Already, however, there are marked variations in wastage rates, and where there has been marked improvement it has not necessarily been on account of a demand for higher educational qualifications of nurses and midwives at entry; it could instead reflect more careful vetting procedures designed to test personality and motivation and more sensible systems of counselling.

422. How serious are turnover rates among trained staff? The figures on page 124 give a broad comparison between nursing and other walks of life. Given that the figures for nurses and midwives include trainees, while those for teachers do not, the length of service of nurses and midwives is not greatly different from that of all manual and non-manual workers and of welfare workers and teachers. However, such global comparisons which aggregate different age groups and grades are of very limited use. Figures from our own research show that the most important variations are between grades. The nursing and midwifery work force has a stable core of sisters, enrolled nurses and older staff nurses and midwives. But there is higher wastage among trainees, and turnover among

younger staff nurses and midwives and auxiliaries. Other relevant conclusions from our research are that about seventy-one per cent of sisters, forty-seven per cent of staff nurses and sixty-three per cent of enrolled nurses in a given twelve-month period had been in continuous service with their present hospital or hospital group since before 1968.

TABLE 28

**PERCENTAGE OF EMPLOYEES IN VARIOUS CATEGORIES WHO
HAD BEEN EMPLOYED BY THEIR CURRENT EMPLOYER FOR
TWELVE MONTHS OR LESS AT 1 APRIL 1971**

<i>Occupational categories</i>	<i>Women in full-time employment*</i>	<i>Women in part-time employment*</i>
	%	%
Nurses and midwives:		
Senior nursing and midwifery staff including sisters and equivalent	9.0	—
Staff nurses and midwives, enrolled nurses and trainees	24.5	19.2
Nursing auxiliaries and assistants	27.3	32.3
Other selected occupational categories:		
School teachers—secondary, primary, nursery and special schools	17.4	20.1
Welfare workers†	24.0	—
Office and communications staff	19.8	21.0
Secretary, shorthand typist	21.0	18.5
Total: manual	18.6	21.5
Total: non-manual	20.0	23.3

Source: Department of Employment New Earnings Survey April 1971.

* Over eighteen years of age on 1 April 1971.

† Including probation officers, children's officers and hospital medical social workers.

423. Factors contributing to wastage and turnover include some which affect any large group of women workers and some which are peculiar to nursing and midwifery. Like teaching, nursing and midwifery show a high rate of withdrawal from the profession in the late twenties which is associated with marriage and childbirth. The most recent figures for teaching¹ suggest that twenty-three per cent of women teachers aged twenty-five to twenty-nine left their jobs in 1969/70.

424. We must distinguish, of course, between leaving a profession and changing from one appointment to another within the profession. As far as nurses and midwives are concerned, general dissatisfaction leads to leaving the National Health Service, while the search for career and promotion opportunities causes movements between hospitals. We believe that it is necessary to clarify career structures and to improve the "internal" labour market within nursing and midwifery itself. Our proposals in Chapters IV and VI should help to do this, particularly our recommendations on basic training which will produce nurses qualified to move rapidly from one setting to another.

425. The present unsatisfactory role of the staff nurse grade may contribute to movement outside and within the system. This is a grade which includes nurses in quite different positions, some consolidating nursing practice immediately after

¹ See list of references, no. 23.

formal training, some set in jobs which they will never leave and where there is frequently no clear differentiation of their role from that of the enrolled nurse. Our career structure proposals in Chapter VI, linked with the progressive pattern of education we are recommending in Chapter IV, should do much to improve the position.

426. We conclude that while there is a good deal of room for improvement, nursing and midwifery have been able in general to retain as well as to recruit staff. For the one group—student nurses—for which evidence is available over long periods of time wastage rates have actually fallen since the 1950s. It is not here that the main weaknesses in the past record of growth are to be sought. In broad terms the main problem has been one of distribution. Within a uniform structure of salary scales and training allowances, it has been other factors which have tended to determine the allocation of recruits. These have worked in such a way that the growth in the labour force we have described has mainly benefited those Regions and hospitals which started in a strong position.

427. Taking recruitment and retention together, the overall performance has been good, but there have been substantial variations between different sectors. The adaptation to changing labour market conditions has been the result of improvised response, sometimes crisis response at the local level, rather than a consequence of a fully evaluated local or national strategy implemented and monitored over the years. This has been so despite the fact that from time to time (for example, through advice given on the recruitment and employment of part-time staff) some valuable guidance has been issued to health authorities. It is because we think that there is considerable scope for further improvement that we make a number of specific recommendations in this chapter.

428. While we go on at a later point to show that the major problems facing the nursing and midwifery service do not arise primarily on the supply side, we do not wish to imply that there are no supply difficulties; indeed, there are some specific issues which demand urgent attention. As for changes of approach on the demand side, these in our view are indispensable. Resources must be so used that skills are matched to needs. This is the challenge for the 1970s, and in order to meet that challenge the nursing and midwifery service should be made still more attractive to potential recruits.

THE PROSPECTS FOR FUTURE SUPPLY: TENDENCIES AND POLICIES

429. Before we turn to the means of meeting the challenge, we consider it is useful to look at future demographic trends and to assess the prospects of the nursing and midwifery service being able to maintain and, should it be necessary and feasible, to increase its competitive attraction in the labour market.

430. The level of intake to nurse training and the number of nurses in training have risen since 1965 whereas the number of eighteen-year-olds has been falling. The facts are set out in Table 29 on page 126. The figures confirm our earlier comment that the National Health Service has been able to improve its recruitment performance. Yet, as was indicated earlier, this has been due in part to the inclusion in the recruitment figures of an increasing number of older entrants and to substantial intakes of immigrant nurses.

TABLE 29

**A COMPARISON, BY INDEX NUMBERS, OF THE NUMBER OF
TRAINEE NURSES WITH THE NUMBER OF EIGHTEEN-YEAR-OLDS
IN THE POPULATION (GREAT BRITAIN)**

<i>Year</i>	<i>Estimated number of eighteen-year-olds</i>	<i>Number of trainees*</i>	<i>Intake of trainee nurses†</i>
1964	79	96	92
1965	100	100	100
1966	83	104	107
1967	80	108	106
1968	78	106	112
1969	75	103	107
1970	74	102	103
1971	76	104	110

Source: DHSS, OPCS, SHHD and WO.

* Includes post-registration student nurses. Figures at 30 September each year.

† Figures for year ending March in each year.

431. It is essential that this performance be maintained, particularly over the next few years before a rise in the number of boys and girls reaching the age of eighteen takes place and when the main dependency groups (the young and the elderly) are expected to increase. The relevant figures are:

TABLE 30

**NUMBER OF EIGHTEEN-YEAR-OLDS. MID-1971 BASED.
PROJECTIONS OF TOTAL POPULATION (GREAT BRITAIN)**

<i>As at mid-year</i>	<i>Natural increase projection*</i>		<i>With migration projection†</i>	
	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
1971 (base population)	389	369	389	369
1972	387	365	387	366
1973	382	360	382	363
1974	396	376	398	380
1975	401	380	404	384
1976	414	393	416	398
1977	421	399	425	405
1978	429	408	434	415
1979	442	420	447	427
1980	457	436	462	443

Source: OPCS.

* The natural increase projection is the projection of the number of eighteen-year-olds with allowance for the number of deaths.

† The "with migration" projection includes the effect of an assumption regarding future migration.

432. 1973, in fact, marks the lowest point and it is not coincidental, therefore, that we are recommending that a start be made in that year to reduce the minimum age of entry (see Chapter IV, paragraph 266 and Chapter VII, paragraph 711). It is the year in which the school leaving age is to be raised. Thus increased competition for seventeen-year-olds and perhaps older people may be expected. A reduction in the age of entry to training will help to meet that competition.

433. In these circumstances, unless the reduction in age of entry has a very marked effect on recruitment, it is essential to offer increased training facilities for the mature entrant. Over the longer term we believe that in the interests of both the National Health Service and society in general the availability of such facilities on a planned basis should form a major part of nursing and midwifery manpower policy. From the point of view of the National Health Service this will help to maintain a balanced work force with a substantial return from the training investment. The contribution of mature entrants can be of particular value to the patient whilst the availability of such work will provide an opportunity for older people who otherwise might have difficulty in finding outlets for their skills and talents.

434. Apart from their contribution as trained staff, mature entrants already play a significant part in recruitment to the nursing auxiliary and assistant grades and are being used increasingly in the community nursing service in a similar capacity. Clearly this rate of recruitment should be maintained as integration proceeds. Indeed, if, as anticipated, our various training recommendations call for additional staff at this level to replace trainee labour, then an increased rate of recruitment will be required. We believe that, given the right facilities and the right conditions of work, on which we comment further in Chapter VI, a drive to increase recruitment of mature entrants could be successful.

435. There should also be a vigorous recruitment drive to attract more male nurses, not only with a view to increasing the number working in the psychiatric field, where we know that additional resources are required, but also to increasing numbers in other branches of nursing, where substantial numbers of male registered mental nurses and registered nurses for the mentally subnormal/defective already take further post-registration courses. We note also with approval that male nurses are to be offered wider career opportunities in health visiting. The educational proposals outlined in Chapter IV should be useful in allowing male nurses the opportunity to experience various facets of nursing.

436. We also believe that it is essential for the future of nursing and midwifery to devote special attention to the recruitment of more A level and graduate entrants, both male and female. Only if their proportion is increased will it be possible for nurses and midwives to develop the research base which we discuss elsewhere, to develop more comprehensive and effective training facilities and to speak on equal terms in the multi-disciplinary teams which will be required to manage an integrated National Health Service. The medical profession consists entirely of graduates. For some years there has been a nationally organised graduate intake to the administrative class in the existing National Health Service, and a parallel scheme for A level entrants is now being developed; there are similar arrangements for the benefit of the pharmaceutical, scientific and technical services. Nursing and midwifery need a comparable voice, and the current labour market situation—with a growing number of graduates looking for alternative sources of employment—provides an ideal opportunity to make major moves to attract graduates into the nursing and midwifery profession. Research surveys such as that by Morrison¹ show both how little graduates now know of the career opportunities in nursing and midwifery and how possible it is

¹ See list of references, no. 81.

to arouse interest. There is a strong case for extending the present experimental training schemes and the bursary scheme which offers a few opportunities for nurses and midwives who have been studying for a first degree on a part-time basis to be granted a final year of study free from the work situation.

437. It is difficult to forecast future trends in the recruitment of immigrant nurses and midwives, partly because the consequences of recent legislation are not yet apparent. It is clear already, however, that more formal and carefully considered selection arrangements will have to be conducted overseas and that would-be trainees will be required to enter into specific commitments. While recognising the valuable contribution of immigrant nurses, it would be unwise in our view for the National Health Service to rely too heavily upon recruitment from overseas. Authorities which depend too heavily upon recruits from overseas could find themselves in great difficulties because of fluctuations within the international labour market.

438. Essential as it is to keep recruitment problems under continuous review, it is also necessary never to overlook the necessity and desirability of attracting trained nurses and midwives back to the service. There are both economic and social reasons for such a policy, and as we noted in paragraph 412, much progress has already been made in this direction. The return on the initial investment in education is increased, and the element of experience is a valuable aspect of the nurse's or midwife's qualifications.

439. Our surveys suggest that future prospects for the continued success for such a policy are good. For instance, we learned from the questions put to qualified nurses and midwives aged fifty or under who were not currently nursing or practising midwifery that only a small proportion were unlikely to seek a nursing or midwifery post at some time in the future. They had received specific training which they wished to use again if the opportunity occurred, and they had, by and large, been satisfied with nursing or midwifery as a job. Another pertinent factor was that those who were likely to seek re-employment were prepared to consider a wide variety of types of work both in hospital and the community even if further training was involved. Few expected to be able to work full time immediately on their return, but they were willing to work a considerable variety of hours, with a significant number being prepared to work permanently at night.

440. It would seem, therefore, that, contrary to some of the evidence we received, the National Health Service is not generally in an exceptionally difficult labour market position when seeking to employ part-time staff. This conclusion is important not only from the point of view of manpower but from the point of view of staff morale, for in our surveys practising nurses and midwives made clear their opinion that although part-time staff should be allowed hours convenient to themselves, in doing so they should not place an unfair burden on the others. While we have heard fears expressed that a high level of part-time working could become not only uneconomic but also unmanageable, we have received no evidence on what that level is. The following figures indicate that there is considerable scope, at least in some areas, for a further extension of part-time working:

TABLE 31

**HOSPITAL NURSING AND MIDWIFERY STAFF: PROPORTION OF
TOTAL WHOLE-TIME EQUIVALENT ACCOUNTED FOR BY PART-
TIME STAFF AT 30 SEPTEMBER 1971**

	<i>Total whole-time equivalent</i>	<i>Whole-time equivalent of part-time staff</i>	<i>Proportion of total whole-time equivalent accounted for by part-time staff</i>
England—Regional hospital boards			
Newcastle	14,983.5	3,412.5	22.8
Leeds	16,784.3	4,616.3	27.5
Sheffield	19,039.1	5,472.1	28.7
East Anglia	7,033.7	2,325.7	33.1
N.W. Metropolitan	17,702.1	3,849.1	21.7
N.E. Metropolitan	15,799.1	3,875.1	24.5
S.E. Metropolitan	16,697.3	4,978.3	29.8
S.W. Metropolitan	16,409.4	3,906.6	23.8
Oxford	8,122.0	2,936.0	36.2
South Western	16,962.4	5,430.4	32.0
Birmingham	16,443.3	4,069.3	24.8
Manchester	22,177.0	6,999.0	31.6
Liverpool	22,754.4	6,308.4	27.7
Wessex	12,494.3	3,610.3	28.9
London undergraduate teaching hospitals	14,308.7	1,061.7	7.4
London post-graduate teaching hospitals	4,170.9	465.9	11.2
Provincial teaching hospitals (England)	11,299.3	2,152.3	19.1
Wales	10,270.9	3,185.9	31.0
Scotland	39,938.0	10,133.0	25.4

Source: DHSS, SHHD and WO.

441. In order to encourage a return to nursing and midwifery, nurses and midwives who for family or other reasons are about to leave should be told that their return will be welcome and means should be devised of maintaining regular contact with them whilst they are not practising. The Health Departments have already suggested that authorities should maintain lists of ex-nurses and midwives who would be prepared to return to work occasionally in periods of difficulty, and we have seen good examples of the suggestions being followed to advantage. Indeed, some nurses and midwives have been encouraged thereby to return to nursing and midwifery on a more permanent basis, when they have seen that their services have been required and appreciated and when they have found themselves able to cope both with their work and with their domestic responsibilities. We recommend that National Health Service authorities should create local facilities whereby ex-nurses and midwives can meet regularly but informally, partly for social purposes and partly to keep in touch with National Health Service developments through such activities as talks and visits and through opportunities for occasional work. On their return to work they will also need reinduction training, and we made recommendations on this point in Chapter IV.

442. In arguing that the recruitment base should be broadened, that nurse and midwife education should facilitate this, and that the career structure (a national structure) should be suitably attractive, we wish to insist on the need for flexibility. Later in this chapter we recommend the creation of adequate planning machinery to quantify the most appropriate balance to maintain between the different

constituents of the work force. We recognise, however, that there is no one single pattern which can or should be universally applied. There will necessarily be variations to meet local circumstances and local people must formulate policies in the light of their own experience and knowledge.

443. The nursing and midwifery service relies heavily and always will rely heavily upon local sources for its staff. This was demonstrated by our opinion survey which showed that eighty-four per cent of nursing auxiliaries and assistants started nursing within the county in which they were living (sixty-one per cent in the same town). The figures for registered nurses in hospitals up to the level of ward sister or equivalent were sixty per cent (and thirty-five per cent) and for enrolled nurses sixty-six per cent (and forty-two per cent).

444. Intelligent and imaginative recruitment policies must begin at the local level within the context of the local labour market. We have seen instances of such policies being pursued at present with success when local labour market conditions seem unfavourable. Even where they are favourable, imaginative policies are still needed so that full advantage can be taken of the situation to improve and diversify the work force.

MANPOWER DISTRIBUTION AND SHORTAGES

445. In seeking to formulate policies which will ensure that nursing and midwifery resources meet the needs of a changing workload, the handicaps we outlined in paragraph 406 of this chapter are serious. No reliable methods of measuring staff requirements have been developed. The research that has been carried out so far on establishments and which we describe in Appendix I is of little relevance outside the area in which it was carried out. We have noted valuable work being done, particularly in Oxford¹ and Aberdeen², on the preparation of formulae which will take into account varying levels of patient dependency; we have studied the plans of the team attached to the Royal College of Nursing³ which is investigating standards of nursing care; and we know of studies which have recommended some broad criteria related to population which can be used to guide local health authorities and their Directors of Nursing Services in determining establishments in the community⁴. So far, however, there are no generally applicable scientific criteria which can usefully be adopted by nursing and midwifery managers. They have little alternative, therefore, but to bargain, often crudely, for a reasonable share of the budget and to spend their allocation in accordance with subjective judgements related to the circumstances and availability of staff at the time. Since nurses and midwives constitute the largest group of staff in the National Health Service and because they have a major coordinating role in the provision of patient care around the clock, it is they who suffer most from a lack of comprehensive staffing policies within the service.

446. In studying the evidence we collected about shortages, we were forced to the conclusion that it is not possible to measure shortages without first establishing needs. When shortages are perceived, the underlying worry often seems to centre

¹ See list of references, no. 98.

² See list of references, nos. 5, 122 & 123.

³ See list of references, no. 70.

⁴ Recently brought together in Circular 13/72 (see list of references, no. 25).

on quantity rather than on quality. Excessive reliance on and pressure on nurses in training can lead to a sense of inadequacy and a high degree of anxiety. So, too, can a very heavy dependence on overseas recruits. Anxiety about the standard of nursing care by day does not seem to be associated with the level of staffing, although anxiety about night cover is general. Where establishment figures exist, their derivation is often obscure; otherwise they seem to be the result of pressures and counter-pressures rather than of rational planning. Thus the term "funded establishment" (i.e., the number of staff for whom money is available) appears frequently in relation to both the hospital and the community nursing services. On the hospital side we meet references to the use of set formulae which until recently had been used by the Health Departments merely to act as a general guide in determining the overall level of financial allocation following the completion of major capital works, and to a deployment study¹ which the Department of Health and Social Security had conducted in order to compare levels of staffing in acute hospitals. Averages of this kind are of interest, but they should not be and never were intended to be a determinant of staffing standards generally. We have concentrated, therefore, on looking at those data which are available to us to see if there are any significant pointers.

447. When the quality of patient care falls below what is felt to be an acceptable level, there is often a sense of shortage, and while for reasons which we have given it is of no use to talk generally of an overall national shortage, it is possible to point to perceived shortages, some of them very serious, in particular places, grades and parts of the service as the service is at present constituted:

- (a) at the staff nurse level. Overall numbers of staff nurses in non-psychiatric hospitals have risen much more slowly than the nursing force as a whole. From 1963 to 1971 while numbers of staff in these hospitals grew overall by twenty-seven per cent, numbers of staff nurses grew by eighteen per cent. In the course of visits we heard a good deal about recruitment difficulties at this level;
- (b) in chronic, geriatric and long-stay hospitals. While in acute hospitals there are roughly 107 nurses to every one hundred beds, in these hospitals there are about forty-three nurses to every one hundred beds. We recognise the obvious differences in the technical content of work. Nevertheless, staff in geriatric hospitals are maintaining a twenty-four-hour-a-day, seven-day-a-week service for patients who in many cases are highly dependent in nursing terms. We recognise the difficulties which are even greater than usual in recruiting for work with psycho-geriatric patients;
- (c) in psychiatric hospitals. We recognise that raising numbers in isolation from improving professional standards is not enough. But numbers and recruitment standards are much too low both in hospitals for the mentally ill and in those for the mentally handicapped. It is significant that new psychiatric units in general hospitals tend to be much better staffed than the older hospitals for the mentally ill. In the case of the mentally handicapped, the effects of staff shortage have been described eloquently in a recent report² of the Hospital Advisory Service:

"It is difficult to convey for those who have no experience of the problems the stress imposed on ward staff. For example, two nurses may be

¹ See list of references, no. 27.

² See list of references, no. 35.

responsible for rousing, dressing and toileting fifty or so severely handicapped patients”.

We deal further with this class of hospitals in paragraphs 460 to 462 below;

- (d) in special units, such as those providing intensive care. On our visits we found that some hospitals had been forced to employ agency staff to work in special units. In such cases casual workers are doing the most advanced work. Others have introduced uneconomic training courses. There has been no overall planning for the manpower needs of these units;
- (e) in the Metropolitan Regions and in certain other Regions for example, Birmingham. In general hospitals, staffing ratios are the lowest in the country in three of the Metropolitan Regions. We are also aware of individual hospitals in these Regions which have had severe difficulties. Staffing problems have produced a heavy dependence on immigrants and an increasing use of agency nurses.

448. The position in the community is less easy to assess. It is often suggested that there is no shortage of community nursing and midwifery staff and support is given to this view by the fairly large number of local health authorities which have waiting lists of qualified staff wishing to work in the community. This does not prove, however, that the services of these local health authorities are necessarily adequately staffed. Their staffing ratios to population may be too low for a number of reasons such as incorrect assessment of need and a desire to spread limited resources fairly amongst several services, including social services and education.

449. Given the lack of criteria for evaluating staff needs at the local level, the picture we present is necessarily impressionistic. In general, we consider that the misallocation and maldistribution of nursing and midwifery resources create even more difficult problems than actual shortages through failure to recruit or to retain. Perceived shortages can rarely be dealt with simply by making up numbers. An improvement in the professional atmosphere is usually required as well and methods have to be devised to achieve the right balance between nurses and midwives and others.

450. As integration proceeds there will have to be significant changes in manpower policies involving both improved manpower information systems and improved manpower planning. We note that in recent years there has been little change in the apportionment of nursing resources (excluding midwives) between the community and hospital nursing services:

TABLE 32

ALL NURSING (BUT NOT MIDWIFERY) STAFF (WHOLE-TIME EQUIVALENT) IN GREAT BRITAIN

	<i>Per cent employed in hospitals</i>	<i>Per cent employed in community nursing</i>
1963	90·8	9·2
1967	91·2	8·8
1971	90·8	9·2

Source: DHSS, SHHD and WO.

Both "sides" of the present service have shared fairly equally in the growth of nursing staff. Staffing on the hospital side has registered a rise in demand because of the increasing complexity of medicine, which we discussed earlier in our Report, the need for a wider range of technical and personal skills in nursing and midwifery and intensification of activity as the average length of stay has fallen (e.g., from 18·1 days in 1962 to 13·9 days in 1971 in the non-psychiatric specialties in England and Wales) and as the number of cases treated has risen.

451. The proportion of work in terms of hours that can be classed as technical nursing has not increased greatly in hospitals over the last fifteen years in acute medical and surgical wards, but we are well aware of the increased psychological pressure that the current technical work and increased patient turnover brings with it for a more varied work force; the creation of intensive care units, special baby care units and renal dialysis units are examples of this. On the psychiatric side there is increased involvement of nurses in active treatment such as group therapy, whilst nurses are asked to contribute to new approaches to care and social education in units for the mentally handicapped. There have been significant developments also in the workload on the community side, such as early discharge of surgery cases, cytology, family planning services and the foundation of developmental assessment clinics, but the number of community nurses has certainly not kept pace with this set of changes.

452. The distribution of work between the hospital and community sectors is changing, but this is not necessarily influencing the present balance in workload. To take midwifery as an example, although most confinements now take place in hospital, early discharge leads to additional post-natal work in the community where much and perhaps more pre-natal work is now taking place.

453. Those responsible in the future for deployment between hospital and community services will need to take workloads and pressures into account when trying within an integrated service to aim at coordinating comprehensive health services focused on groups of people with particular needs. Nor must it be overlooked that in trying to extend community activity and to link it to hospital activity there will be difficult problems associated with geography, transport and the economics of staffing. Careful planning and adequate personnel policies will be essential.

454. Of particular relevance to changes of this sort are the views expressed in our survey which showed that only nine per cent of community nurses and midwives were definitely prepared to consider a transfer to hospital work and only a further twenty-five per cent would probably be prepared to consider such a change. A large proportion of hospital nurses and midwives were prepared to think about working in the community, but only eighteen per cent were at all definite. There should be increased opportunities of offering part-time work in the community as re-allocations of work take place. As the proportion of married women in the profession increases, there is likely to be a greater demand for the kind of flexible hours which work in the community can offer. We also hope that a greater willingness to work in other settings will result from the implementation of our proposals, set out in Chapter IV, for wider experience during basic training.

455. The fact that the proportion of hospital nursing work which is technical has remained roughly constant in recent years leads us to believe that the expansion of the enrolled nurse grade and the increased use of nursing auxiliaries and assistants, in addition to preventing what otherwise might have been severe shortages, has led to a more appropriate distribution of work. We are aware that the borderlines between categories of nurses are blurred and that different practices in the distribution of work occur (and later in this chapter we discuss variations in staffing levels), but the trend has been beneficial to the service. Similar developments are taking place in the community nursing service following recommendations¹ from the Standing Nursing Advisory Committee in 1965. It has not been possible, however, to obtain the full benefit of this trend, partly because the career structure, which tends to erect barriers to career progression, was designed in earlier days. The recent report² of the Standing Nursing Advisory Committee on the extended use of enrolled nurses is an attempt to mitigate the effects of one barrier. Our more flexible proposals in Chapters IV and VI are aimed to secure benefits both for the nurse and the service.

PSYCHIATRIC HOSPITALS

456. Much has been written recently about psychiatric hospitals, which have been the subject of many enquiries and for which the Hospital Advisory Service was primarily created, and of the development of future services. These involve seeking over a period of time to reduce their sense of isolation, to improve the quality of life they offer and to provide far more support in the community, including hostels for the mentally handicapped.

457. At present, staffing patterns in psychiatric hospitals are different from those in other parts of the hospital service, as the table on page 135 shows. Apart from illustrating the limitations of looking at nursing statistics in the aggregate, these figures show that psychiatric hospitals have developed somewhat more extensively than other institutions the use of the enrolled nurse grade, which was introduced to these hospitals only in 1965 when many existing nursing assistants qualified for enrolment on the grounds of experience.

458. As we showed in Chapter III, the educational level of students opting for the psychiatric part of the register is lower than that for other parts. On the other hand, there is less dependency on trainees. In part, this is a reflection of the fact, which we have noted earlier, that more than one-third of the staff in these hospitals is male. This accounts, no doubt, at least partially, for the somewhat older age distribution (fifty-four per cent in mental illness hospitals and seventy-three per cent in hospitals for the mentally handicapped are aged forty or more compared with thirty-two per cent in acute hospitals) and for longer continuity of service with the present employing authority (within psychiatric hospitals as a whole thirty per cent joined their present authority before 1960 and eighty-nine per cent in 1967 or earlier; comparable figures for acute hospitals are eleven per cent and fifty per cent).

¹ See list of references, no. 17.

² See list of references, no. 16.

TABLE 33

PERCENTAGE DISTRIBUTION OF NURSING STAFF, BY GRADE, AT 30 SEPTEMBER 1971*

	Mental illness hospitals England and Wales	Mental illness units Scotland	Mental handicap hospitals England and Wales	Mental deficiency units Scotland	Acute, mainly acute and partly acute hospitals England and Wales	Units other than mental illness and mental deficiency Scotland	Other hospitals England and Wales
	%	%	%	%	%	%	%
Nursing officer and above	4.8	5.0	5.3	4.5	4.1	3.7	6.3
Ward sister/charge nurse†	18.9	17.8	16.5	15.7	13.2	9.9	12.9
Staff nurse	12.4	12.0	7.1	7.2	15.3	13.0	10.1
Enrolled nurse	21.6	17.8	22.9	15.6	12.0	12.7	17.6
Student nurse‡	17.6	15.1	10.8	8.5	26.6	18.4	9.1
Pupil nurse	7.4	7.4	5.8	6.7	10.3	8.5	7.1
Others	17.3	24.9	31.6	41.8	18.5	33.8	36.9

Source: DHSS, SHHD and WO.

* Columns may not sum to 100 due to rounding.

† Includes deputy ward sisters/charge nurses.

‡ Includes post-registration student nurses.

459. We have also noted a higher dependency on nurses from overseas. Thus seventy-four per cent of nurses in psychiatric hospitals were born in the United Kingdom to a father also born in the United Kingdom, whereas eighty-three per cent of nurses in other hospitals fell into this category.

460. Earlier in this chapter we have commented on the fact that male nurses who train for a qualification tend to enter nursing rather later in life as a change in career. Women who train for psychiatric hospitals also enter somewhat later than women joining other hospitals. The following figures, which include nursing auxiliaries and assistants, who do not distort the analysis significantly, show the position:

TABLE 34
PERCENTAGE DISTRIBUTION OF AGE OF ENTERING NURSING*

	<i>Psychiatric hospitals</i>		<i>Acute hospitals</i>		<i>Other hospitals</i>	
	<i>Male</i>	<i>Female</i>	<i>Male</i>	<i>Female</i>	<i>Male</i>	<i>Female</i>
	%	%	%	%	%	%
Less than 20	19	35	20	57	20	54
20-29	58	31	57	25	56	25
30 or more	21	27	21	15	19	17

Source: Postal survey.

* Columns may not sum to 100 due to rounding.

461. At the time of our survey, the standard working week was forty-two hours and overtime was payable in psychiatric hospitals only. In such circumstances one can draw a number of differing conclusions from the following figures which make no allowance for the fact that nursing rotas tend to be drawn up in terms of a unit longer than one week. Nevertheless, we think it worth recording what the respondents in our survey told us:

TABLE 35
PERCENTAGE OF WHOLE-TIME NURSES AND MIDWIVES, BY HOURS OF WORK DURING LAST WORKING WEEK*

<i>Hours worked</i>	<i>Acute hospitals</i>	<i>Mental illness hospitals</i>	<i>Hospitals for mentally handicapped</i>	<i>Long-stay hospitals</i>	<i>Other hospitals</i>
	%	%	%	%	%
Less than 42	24	12	10	11	18
42	50	52	49	63	54
43	7	3	3	4	7
44	4	4	7	6	4
45 or more	9	23	27	6	9
Not known	6	6	4	9	7

Source: Postal survey.

*Columns may not sum to 100 due to rounding.

PERCENTAGE OF NURSES AND MIDWIVES (WHOLE-TIME AND PART-TIME) WHO WORKED UNPAID OVERTIME DURING LAST WORKING WEEK*

<i>Hours of unpaid overtime</i>	<i>Acute hospitals</i>	<i>Mental illness hospitals</i>	<i>Hospitals for mentally handicapped</i>	<i>Long-stay hospitals</i>	<i>Other hospitals</i>
	%	%	%	%	%
Nil	59	77	77	76	62
Less than 1	11	2	1	2	11
1-2	11	3	2	3	9
2-5	8	4	4	4	7
5 or more	2	4	6	1	3
Not stated	9	10	10	13	10

Source: Postal survey.

* Columns may not sum to 100 due to rounding.

462. Our proposals on education which we set out in Chapter IV will offer, we hope, an opportunity to redress some of these inequalities. As a result of the broader base for initial training, nurses will be able to practise at the Certificate level in any type of hospital or community setting. This will allow nurses to be employed near their homes, and also to move from one type of nursing to another with a short period of "up-dating" or further training. Similarly, opportunities will be given for nurses to continue training for Registration in another locality, or with the main emphasis on another type of nursing. Specialised nursing courses at the Higher Certificate level, to be taken before or after Registration, will prepare nurses with particular clinical expertise in subjects such as paediatric nursing, or the nursing of the mentally ill or the mentally handicapped. This greater flexibility, together with the provision of advanced level and other specialised courses and in-service education should contribute both quantitatively and qualitatively to the nursing labour force at national and local level.

REGIONAL VARIATIONS

463. We have noted throughout our studies variations in the levels and mix of staffing not only between types of hospital but also between hospital authorities, between hospital Regions and between local health authorities. In the absence of agreed measures of need to which we have referred, variations in local and regional provision deserve special attention. Our own study of some of the relevant figures about nursing and midwifery has confirmed opinions expressed in a number of other studies, for instance those by Davies¹ and by Cooper and Culyer², and convinced us of the necessity to plan for more "territorial justice". Inevitably there are difficulties in such planning, particularly in present circumstances, when information flows are inadequate and comparative data may be misleading.

464. The facilities inherited by the National Health Service were unevenly distributed, and only limited progress has been made in correcting the balance,

¹ See list of references, no. 20.

² See list of references, no. 19.

while the case mix to be treated, the size of the catchment areas and other geographical factors, the age distribution and the socio-economic characteristics of the population justify variations in nursing and midwifery staffing.

465. Bearing necessary qualifications in mind, we have looked at numerous figures related to nursing and midwifery, including staff per bed, per patient and per case (variously defined), at levels of expenditure on salaries and at levels of staffing in relation to population. We cannot include them all in this Report (many appear, indeed, in other publications), but we think it important to draw attention to a few selected indicators. In doing so we have not been able to follow a fully consistent pattern as far as the teaching hospitals are concerned, because comparable statistics are not always available. Some such hospitals, particularly in Scotland, fall within the regional structure while others have separate Boards of Governors. We deal with London separately in the section which follows this. Here we point to a number of general conclusions.

466. The distribution of nursing and midwifery staff seems to bear a limited relationship to the distribution of population. This is demonstrated by the following figures which, apart from reflecting the impact of teaching hospital staffing, show that there are wide variations in both the hospital and community services. Within the hospital service the area with the highest staffing level is about forty per cent better off than that with the lowest level; in the community services the difference is almost thirty per cent. Aggregations at this level hide even wider variations at hospital and local health authority levels. We also note that only to a limited extent do hospital and community service staffing levels seem to be compensatory; indeed there are examples of comparatively high or low staffing in both sectors. We are convinced that differences of this order cannot be justified, whatever the deficiencies in the data.

TABLE 37

REGIONAL DISTRIBUTION OF NURSES AND MIDWIVES
(WHOLE-TIME EQUIVALENTS, 1971)
PER 1,000 POPULATION

Area	Hospital nurses and midwives		Community nurses and midwives*	Total
	RHB hospitals only	RHB and BG hospitals		
Newcastle	4.91	5.26	0.47	5.73
Leeds	5.19	5.49	0.44	5.93
Sheffield	4.09	4.43	0.49	4.92
East Anglia	3.99	4.50	0.45	4.95
N.W. Metropolitan	4.28	5.96	0.46	6.42
N.E. Metropolitan	4.69			
S.E. Metropolitan	4.72			
S.W. Metropolitan	5.08			
Oxford	4.06	4.77	0.53	5.30
South Western	5.33	5.74	0.52	6.26
Birmingham	4.33	4.63	0.49	5.12
Manchester	4.98	5.24	0.54	5.78
Liverpool	5.62	6.26	0.49	6.75
Wessex	5.05	5.05	0.46	5.51
Wales	6.03	6.03	0.56	6.59
Scotland	7.56	7.56	0.67	8.23

Source: DHSS, SHHD and WO.

* Nurses and midwives within each Regional Hospital Board area were added together and divided by the population.

467. It is of doubtful value, however, to look at levels of nursing and midwifery staffing in isolation, for, as we have argued above, it is necessary to consider the National Health Service work force as a whole. While there is no one single “correct” mix between different classes of staff who may, and ought, to be able to some extent to be substituted for each other, the following figures should be read in conjunction with the previous table:

TABLE 38

WHOLE-TIME EQUIVALENT OF SELECTED CLASSES OF
HOSPITAL STAFF PER ONE HUNDRED WHOLE-TIME
EQUIVALENT NURSES AND MIDWIVES AT 30 SEPTEMBER 1971

	<i>All medical and dental</i>	<i>Physio- therapists</i>	<i>Occupational therapists</i>	<i>Domestic staff</i>	<i>Ward orderlies</i>	<i>Porters</i>
England—Regional Hospital Boards						
Newcastle	9.87	1.09	0.35	28.88	2.77	5.89
Leeds	7.79	1.36	0.53	25.91	6.04	7.94
Sheffield	8.48	1.25	0.62	27.29	5.64	6.27
East Anglia	9.35	1.62	0.82	24.74	5.99	7.15
N.W. Metropolitan	11.38	1.84	0.90	24.36	6.74	8.09
N.E. Metropolitan	9.92	1.53	0.79	25.00	8.32	9.05
S.E. Metropolitan	9.92	1.78	0.69	26.91	5.99	10.07
S.W. Metropolitan	9.82	2.08	0.93	22.32	8.04	9.01
Oxford	11.11	2.09	1.12	19.57	6.00	6.83
South Western	9.37	1.90	0.61	24.10	3.13	6.75
Birmingham	9.75	1.81	0.55	25.87	4.00	6.71
Manchester	8.49	1.51	0.40	24.82	2.94	6.47
Liverpool	8.56	1.13	0.58	25.94	6.18	7.98
Wessex	10.13	2.01	0.78	26.04	1.75	7.73
London undergraduate teaching hospitals	19.34	3.21	0.76	30.83	8.83	12.97
London post-graduate teaching hospitals	25.01	3.21	1.03	31.63	9.49	13.57
Provincial teaching hospitals (England)	20.32	2.62	0.54	30.78	7.90	9.51
Wales	9.24	1.42	0.52	27.83	3.23	7.16
Scotland	10.38	1.60	0.54	22.32	4.29	5.11

Source: DHSS, SHHD and WO.

468. This table shows that while some differences in nursing and midwifery staffing levels involve compensatory provisions elsewhere, this is by no means always the case. Indeed, there are examples of unacceptable variations in nursing and midwifery apparently being aggravated by variations in the levels of other staffing. The general picture is one of inconsistency, with the following points standing out:

- (a) it might be expected that the numbers of nurses and midwives would reflect the number of doctors working in different areas, particularly since, as was stated in paragraph 409, growth in the numbers of both has been fairly consistent nationally. But there are examples of areas with either high or low nursing and midwifery complements when related to population which also have low ratios of doctors to nurses and midwives, and others with comparatively low levels of nursing and midwifery staff yet high doctor ratios;

TABLE 39

**HOSPITAL NURSING STAFF—GROWTH IN WHOLE-TIME EQUIVALENT*, 30 SEPTEMBER 1963 TO 1971:
ANALYSIS BY GRADE AND REGION**

	Registered			Enrolled			Trainees†			Other nursing staff			Total		
	1963	1971	Per cent increase	1963	1971	Per cent increase	1963	1971	Per cent increase	1963	1971	Per cent increase	1963	1971	Per cent increase
Great Britain—total	75,964	89,984	18.5	17,692	43,687	146.9	72,258	80,635	11.6	56,402	71,089	26.0	222,316	285,395	28.4
England—Regional															
Hospital Boards															
Newcastle	3,998	4,741	18.6	1,115	2,692	141.4	3,397	3,621	6.6	2,992	3,081	3.0	11,502	14,135	22.9
Leeds	3,869	4,732	22.3	1,240	2,862	130.8	3,455	4,422	28.0	3,207	3,941	22.9	11,771	15,957	35.6
Sheffield	4,314	5,442	26.1	1,191	3,123	162.2	3,910	4,310	10.2	4,017	5,038	25.4	13,432	17,913	33.4
East Anglia	1,660	2,141	29.0	357	974	172.8	1,049	1,634	55.8	1,597	1,947	21.9	4,663	6,696	43.6
N.W. Metropolitan	5,067	5,670	11.9	761	2,264	197.5	5,015	5,621	12.1	2,728	2,970	8.9	13,571	16,525	21.8
N.E. Metropolitan	4,210	4,363	3.6	791	2,124	168.5	4,469	5,167	15.6	2,816	3,063	8.8	12,286	14,717	19.8
S.E. Metropolitan	4,892	5,199	6.3	1,186	2,406	102.9	4,233	4,267	0.8	3,339	3,771	12.9	13,650	15,643	14.6
S.W. Metropolitan	5,671	5,702	0.5	713	2,362	231.3	4,632	4,642	0.2	3,365	2,873	-14.6	14,381	15,579	8.3
Oxford	1,887	2,457	30.2	387	1,039	168.5	1,643	1,740	5.9	1,849	2,439	31.9	5,766	7,675	33.1
South Western	4,365	5,183	18.7	1,141	2,676	134.5	3,017	3,565	18.2	4,227	4,627	9.5	12,750	16,051	25.9
Birmingham	4,847	6,087	25.6	1,388	3,503	152.4	4,441	4,925	10.9	4,539	6,315	39.1	15,215	20,830	36.9
Manchester	5,131	6,549	27.6	1,331	3,478	161.3	4,737	5,820	22.9	4,677	5,517	18.0	15,876	21,364	34.6
Liverpool	3,026	3,442	13.7	1,033	2,199	112.9	3,117	3,307	6.1	2,540	2,948	16.1	9,716	11,896	22.4
Wessex	2,651	3,273	23.5	630	1,480	134.9	1,897	2,348	23.8	2,189	2,610	19.0	7,367	9,711	31.8
All teaching hospitals	7,507	9,540	27.1	810	2,719	235.7	12,843	12,273	-4.4	1,238	3,420	176.3	22,398	27,952	24.8
Wales	3,919	4,985	27.2	1,386	2,622	89.2	2,314	3,576	54.5	3,389	4,431	30.7	11,008	15,614	41.8
Scotland	8,952	10,480	17.1	2,232	5,167	131.5	8,089	9,399	16.2	7,690	12,098	57.3	26,963	37,144	37.8

Sources DHSS, SHHD and WO.

* Whole-time equivalent to nearest whole number.

† Trainees include post-registration students.

- (b) similarly there seems to be no compensatory pattern in the relationship of provision between nursing and midwifery staff and some of the professions supplementary to medicine: there are wide variations between the lowest and highest ratios, with the higher ratios mainly in the southern regions of the country;
- (c) in view of the frequent discussions about the allocation of non-nursing duties it might be expected that there would be a compensatory relationship between the levels of domestic/ward orderly staffing (we should take the two together for our purposes here) and those of nursing and midwifery. There are areas where this is so, but there are also examples of apparently high or low provision of both types of staff.

469. All these figures merely record the current position. Given that different areas now encompassed within the National Health Service inherited unevenly distributed resources, have there been improvements over the subsequent years? Has the growth we have recorded in earlier paragraphs been used to achieve a more equitable distribution? The figures on page 140 are not very encouraging when read in conjunction with the figures in paragraph 466.

470. There are examples of Regions increasing the number of their nurses and midwives at a faster rate than others but still having poor ratios of nursing and midwifery staff to population. On the other hand, there are also examples of Regions which appear to be comparatively well endowed with staff increasing their staff at quite a fast rate and others which seem to have a particularly low supply of staff not increasing their nursing and midwifery work force as quickly as others. The table also demonstrates the trend, discussed earlier, towards an increase in the proportion of enrolled to registered nurses, but the trend here also is uneven. By and large, the major expansion in the enrolled nurse grade has been in areas where staffing levels appear to be low, yet there are exceptions just as there are examples of major expansion in the number of trainees in Regions whose staffing levels are better than most. Similarly changes in the number of auxiliaries/assistants reflect a variety of responses to developments in the levels of trained staff.

THE SPECIAL POSITION OF LONDON

471. We have noted some of the main differences between the London area and other parts of the country in order to identify special problems requiring special attention:

- (a) the age distribution of nursing and midwifery staff in hospitals in the Greater London area¹ is markedly different from that in the country as a whole as Table 40 after sub-paragraph (b) shows;
- (b) the difference can be accounted for in different ways, but is due mainly to the fact that there is a larger proportion of trainees, particularly in the Central London area, and a smaller proportion of nursing auxiliaries. Thus, for instance, in acute hospitals in the Greater London area 29·7 per cent of the work force in non-teaching hospitals and 47·5 per cent in teaching

¹ The area of the Greater London Council. All hospital authorities whose main address falls within this area and London borough local health authorities have been included as appropriate.

hospitals are student nurses, whereas for the country as a whole the figure is 26·1 per cent. The percentages for auxiliaries/assistants in the same hospitals are 11·5 per cent and 7·1 per cent respectively compared with 16·6 per cent. On the other hand, the teaching hospitals, but not the non-teaching hospitals, have a smaller proportion of pupil nurses;

TABLE 40

AGE DISTRIBUTION OF NURSING AND MIDWIFERY STAFF*

<i>Age</i>	<i>Greater London</i>		<i>Percentage distribution</i>	
	<i>Teaching hospitals only</i>	<i>Non-teaching hospitals only</i>	<i>All Greater London hospitals</i>	<i>Great Britain</i>
Under 25	50	35	41	29
25-29	15	18	17	12
30-39	15	16	15	19
40-49	11	13	12	19
50-59	5	12	9	} 19
60 or more	2	3	3	

Source: Postal survey.

* Columns may not sum to 100 due to rounding.

(c) there are also differences between London and other parts of the country in the employment of part-time staff:

TABLE 41

**WHOLE-TIME AND PART-TIME WORK BY NURSES AND MIDWIVES
IN GREATER LONDON AT 30 SEPTEMBER 1971**

	<i>Number of nurses and midwives</i>	<i>Whole-time equivalent</i>	<i>Average proportion of whole-time hours provided by each nurse or midwife</i>
England and Wales	304,927	263,452	0·86
Non-teaching hospitals in Greater London	34,451*	30,908*	0·90*
London undergraduate hospitals	14,869	14,309	0·96
London post-graduate hospitals	4,387	4,171	0·95

* At 30 September 1970.

Source: DHSS and WO.

(d) these figures, however, do not present the full picture since the London hospitals are unable to attract sufficient qualified nursing and midwifery staff. They have, therefore, come to rely substantially upon agency staff; in fact on 30 September 1971 the equivalent of 2,720 agency nurses and midwives working whole time were being employed in the area of Central London and the four Metropolitan Regional Hospital Boards. This was nine times more than in the whole of the rest of England and Wales. Fifty-four per cent were employed in the teaching hospitals, which employed only eleven per cent of National Health Service nursing and midwifery staff. In the undergraduate teaching hospitals twenty-five per cent of staff nurse and twelve per cent of enrolled nurse time was provided by agency

staff; in the post-graduate hospitals the equivalent figures were as high as thirty-five per cent and eleven per cent. Whatever the reasons why so many nurses and midwives have chosen to work via agencies, the labour market in London is such that opportunities have arisen for them to secure employment on the terms which agencies offer. This, at least in part, is due to social and geographic factors and the siting of some hospitals in areas which do not serve as a good recruitment base for staff. Yet personnel policies to overcome the problem as far as possible are urgently needed, for the excessive use of agency nurses is not a desirable feature of permanent staffing. We understand that the Department of Health and Social Security are currently studying, in conjunction with the Teaching Hospitals Association, the possibility of an agency to be run initially on a limited basis by the Association. Such an arrangement would avoid many of the problems of a Government-sponsored agency, while offering many of the advantages, and we hope that the outcome of this study will be favourable;

- (e) we also note the high dependency of London hospitals on nurses from overseas. For instance, in 1970 some sixty-two per cent of students, pupils and pupil midwives in the non-teaching hospitals of the Greater London area (seventy-two per cent in the N.E. Metropolitan R.H.B. area as a whole) were born overseas (mainly in the Commonwealth), of whom about half were recruited overseas. Comparative figures for the London undergraduate and post-graduate teaching hospitals were seventeen per cent and twenty per cent respectively. In our own survey we found that twenty-one per cent of all nurses in the four Metropolitan R.H.B. areas (as a whole) had been born in a developing country of an indigenous father and arrived in the United Kingdom after the age of sixteen; forty per cent of such nurses currently practising in Great Britain were working in those areas which employed only nineteen per cent of all nurses;
- (f) the community nursing and midwifery services in the Greater London area exhibit some characteristics not dissimilar from those of hospital nursing. For instance, the age distribution is also younger than in Great Britain generally:

TABLE 42

PERCENTAGE DISTRIBUTION, BY AGE GROUP, OF
COMMUNITY NURSES AND MIDWIVES*

<i>Age</i>	<i>London boroughs</i>	<i>Great Britain</i>
Under 25	8	2
25-29	11	8
30-39	25	25
40-49	26	32
50 and over	29	33

Source: Opinion survey.

* Columns may not sum to 100 due to rounding.

Coupled with this there is somewhat more mobility amongst community nurses and midwives in the London boroughs than elsewhere. Our survey showed that fifty-seven per cent took up their posts with their current employing authority before 1968 compared with sixty-six per cent in Great Britain as a whole. Comparative figures for the hospital service,

- where the problem is even more accentuated, are twenty-nine per cent in the Greater London area and fifty-four per cent in the country generally;
- (g) there is also a somewhat greater reliance in London on community nurses and midwives from overseas than in Great Britain as a whole. Our survey showed that nine per cent of community nurses and midwives working in the London area were born in an under-developed country of a father also born in the same country; the national figure was just over two per cent of community nurses and midwives;
- (h) the London boroughs have a different composition by grade in the community nursing and midwifery labour force as indicated by the following figures:

TABLE 43

PERCENTAGE DISTRIBUTION OF COMMUNITY NURSES* AND MIDWIVES, BY GRADE, (WHOLE-TIME EQUIVALENT, 1971)†

	<i>London boroughs</i>	<i>England and Wales</i>	
		<i>County boroughs</i>	<i>County councils</i>
Administrative and supervisory staff	6.3	5.4	3.3
Health visitors	23.8	22.2	24.7
Health visitor trainees	4.9	3.5	3.0
Home nurses (including trainees)	34.4	34.6	39.6
Domiciliary midwives	9.3	16.5	19.0
Pupil midwives	5.5	5.4	2.5
Other qualified (including TB visitors)	9.1	6.6	4.4
Other staff	6.7	5.9	3.4

Source: DHSS and WO.

* Excludes group advisers, school health nurses and nurse tutors employed by LHAs.

† Columns may not sum to 100 due to rounding.

Where midwives are concerned, this difference appears to be largely the result of the fact that the domiciliary confinement rate is somewhat lower in London than elsewhere.

472. Summing up, we note that hospitals in the Greater London area provide training for some twenty-three per cent of all trainees, yet that only about fourteen per cent of the population lives within its boundaries: within those boundaries about fourteen per cent of the occupied hospital beds are located. The teaching hospitals with their capacity to attract recruits to an area which is largely non-residential (which *inter alia* creates accommodation problems for those who are recruited) and which need to compete for staff with other hospitals in residential districts nearby contribute to staffing maldistribution.

473. There are understandable historical reasons for London's special position, which may alter as some of the teaching hospitals are redeveloped away from the centre of London. Yet the general situation from the patient's point of view is far from satisfactory—over-reliance on trainee labour; over-dependence on agency nurses and midwives; and too heavy a concentration of overseas nurses and midwives. Problems of recruitment and retention of suitably qualified community

nursing and midwifery staff are similarly more acute in the London area, particularly in the Inner London area, than in most other parts of the country; this is an area, too, where the usual urban problems for the nursing and midwifery services are aggravated by particular factors such as a highly mobile population, large numbers of "high risk" groups and a lack of family support.

474. We appreciate that it will not be easy to resolve the various special problems of nursing and midwifery in London and that solutions can only be evolved over the course of time. Yet we emphasise that an attempt to find them must be made in the interests both of patients and nurses and midwives. An early improvement is necessary if the educational proposals set out in this Report are to succeed. Apart from demanding the presence in the hospital service of adequate numbers of trained staff fully able to support trainees and of sufficient nursing aides, our educational recommendations also require the availability of more community experience than is being provided at the moment. We have been told that, in some areas, providing such experience is already proving difficult even at present before integration policies have evolved far, and it will clearly be necessary in future to seek such facilities in areas outside London for nursing students in the city.

475. Another major aggravation of the problem in London, particularly in the community nursing and midwifery services, is the confusing network of diverse administrative boundaries. The Inner London Education Authority is at present responsible for the provision of the school health service in Inner London and employs local authority staff for this purpose, but the ILEA and borough boundaries are not congruent. Patients cross boundaries when attending hospital so the community services are particularly vulnerable to differing discharge policies and procedures. The structure of general medical practice is a further complicating issue. In many instances a single practice area impinges upon several local authority areas. This and a high incidence of one-doctor practices inhibit the development of satisfactory attachment schemes. Thus London is trying to meet big city problems with administrative machinery quite unsuitable for the purpose. We trust that the structure devised for the integrated National Health Service in 1974 will be more appropriate to the nursing and midwifery needs of London.

FUTURE POLICIES AND PLANNING MACHINERY

476. The different sections of this chapter have revealed partial adaptation to a changing labour market, with not unreasonable hopes for future recruitment, particularly if steps are taken to diversify further the range of recruits. Yet there has been no strategy. The growth in the labour force has mainly benefited those Regions and hospitals which were in strong positions to start with. This situation leaves major problems which will have to be faced by the service after integration. Nursing and midwifery are at present operating within a system where inadequate attention is paid to the planning and coordination of service provision as a whole. This, of course, is no new discovery of our Committee: it has been the main national concern behind all the thinking that has led to numerous Green Papers, Consultative Documents, White Papers and proposals for the reorganisation of the National Health Service.

477. What we ourselves have done is, first, to identify those nursing and midwifery problems which stem from the absence of proper planning machinery,

second, to make some recommendations which can be implemented immediately or in the near future and which we think will help to improve the situation, and, third, given the complexity of that situation, the short time at our disposal and our lack of knowledge of the detailed form which the integrated service will take, to urge the need to create an organisational framework whereby planning can become more efficient.

478. Any new planning apparatus must take account of the importance of relating work to be done in nursing and midwifery to the demands for different types of staff; of relating demand to supply by developing relevant staffing and training; and of ensuring that financial resources can be allocated on a basis that secures a more equitable distribution.

479. Organisational structures are not ends in themselves, and in nursing and midwifery they do no more than determine the conditions, for good or ill, in which the primary objective is pursued, that which we set out in Chapter I—the provision of the best possible care by nurses or midwives in direct contact with patients. Three general principles are important from this point of view:

- (a) by far the strongest incentive towards the better use of manpower is the aspirations of nurses or midwives themselves and the satisfaction of these aspirations through a full and proper use of their professional competence. We have tried to remove obstacles which stand in the way of this motivation and to suggest a supporting organisation which allows it full expression. We have rejected any proposals for educational reform which would remove the direct and practical relationship with the patient on which the British system of training has been founded;
- (b) following directly from our first principle, we do not see nursing management as something distinct from nursing practice. All nurses and midwives are managers of their own time and skills, and, as we suggested in Chapter I, this is nowhere more true than when they are providing care directly to the patient;
- (c) by nursing management we mean the matching of resources to needs, and believe that a very different style of management is needed from the present one, in the interests both of patients and staff. We have been impressed by the lack of clearly defined objectives which the nursing and midwifery services are supposed to be pursuing. It is taken for granted that the needs of the patient always have priority, but there is at present no intermediate statement of objectives between that very broad one, and the very detailed kind of statement which comes from studies of specific nursing procedures, such as those that are currently being studied by the Royal College of Nursing. As one of our main recommendations we propose the immediate establishment of manpower and personnel departments at Area Health Authority/Board level, and urge that in an integrated service these should cover all categories of staff.

480. The importance we attach to the development of sound and comprehensive personnel policies follows directly from our concern about the motivation of the practising nurse and midwife. Problems and dilemmas in the allocation of manpower at ward level are too often resolved on a makeshift basis without adequate safeguards for the needs of the staff. Reductions in the length of stay have significantly increased dependency levels and the workload of nurses and midwives.

Together with the increasing complexity of medicine, reduced length of stay has meant much greater pressure on ward staff. This increase in pressure has in general been a much more significant change for nurses and midwives so far than any in technology, yet there has been no growth of the personnel function comparable with that in private industry where technological changes have created similar problems. Greater numbers of specialists are now making demands on the patient in a shorter period of time. All these demands have to be coordinated by the ward sister and by ward staff. The numbers of movements in and out of a male medical ward in a London teaching hospital, as set out below, illustrate the pressures which impinge on the ward on a random day: the staff included doctors, medical students, physiotherapists, etc. Nearly all consulted the ward sister as they came in:

TABLE 44

ANALYSIS OF MOVEMENTS OTHER THAN WARD STAFF BUT
EXCLUDING VISITORS TO PATIENTS

Male medical—one day's statistics						
Time of day	Moved in	Moved out	Average on ward	Min. on ward	Max. on ward	Total movements
0943–1000	11	8	5.1	3	7	19
1000–1100	28	25	4.9	2	8	53
1100–1200	16	19	5.5	3	8	35
1200–1300	13	15	3.5	1	6	28
1300–1400	9	8	2.4	1	5	17
1400–1500	16	16	2.4	2	3	32
1500–1600	28	23	7.4	4	13	51
1600–1645	8	15	1.0	—	2	23

Source: University College Hospital.

481. The feeling of pressure is reinforced by the physical strain of the work. In few jobs is so much heavy lifting and so much walking involved. The average nurse walks several miles a day in the course of her duties. Long hours, early starts and late finishes often create a general sense of fatigue. If on a shift rota a late turn one day is followed by an early one the next, one working spell may almost merge into another in a haze of tiredness. In addition there is the emotional strain involved in direct personal contacts with anxious patients, including those with terminal illness. Clearly there is exceptional stimulus and reward too and the job is rarely boring. Nevertheless, nursing is a hard job mentally, physically and emotionally.

482. There are still vital problems and dilemmas in the allocation of manpower at ward level. There is a clash of priorities between establishing a firm shift system in which duties are known some time ahead and responding flexibly to changing workloads. From this point of view the traditional ward is too small a unit to which to allocate staff. The workload fluctuates between wards as well as within wards. Solutions are not likely to be found unless the ward sister in dealing with the day-to-day needs of the patient is sufficiently freed from other demands on her or his time to deal effectively with both personnel management and manpower planning at the ward level. The senior nurse or midwife who leads a nursing or midwifery team at the working level has a unique and heavy responsibility, as we pointed out in Chapter II, for seeing that the patient's needs are met. She or he should be able to look to higher levels of nursing management for support in this area. She or he must be able to plan her or his own use of resources in a way

which allows the nursing manager at the next higher level to coordinate manpower allocation and needs over a wider area and over a longer period of time.

483. As we pointed out in Chapter II, there is evidence in our surveys of some concern among nurses and midwives about the adequacy of arrangements for shift systems, starting times and staff welfare. Procedures for dealing with individual grievances do not compare favourably with those available to many employees in industry, and there would also be benefits both to managers and staff if agreed procedures for staff appraisal were instituted. Taken together with the need at establishment level for particularised recruitment and retention policies, these show considerable scope for improving the personnel function within nursing line management.

484. There is a great need for improvement in the way that nursing and midwifery time is used. We discuss the importance in this context of the economics of manpower utilisation and work study techniques in paragraphs 507 *et seq.* This is all the more important because of the increase in expenditures on training which is involved in our recommendations. Until now expenditures on training on a *per capita* basis have been rather small. Even taking into account the estimated cost of the ward sister's teaching time, tuition costs for nurses are only about £100 a year. Most of the training has been learning by doing. Our proposals will lead to an increase in educational expenditure *per capita*. They make sense if and only if career structures can be improved, wastage reduced, more effective use made of nursing and midwifery time and effort on education more closely related to the pattern of skills required.

485. In Chapter VI we discuss some of the changes in working conditions which could relieve the stress on the individual nurse. In our view the Salmon and Mayston Reports, from which present structures derived, did not give quite enough emphasis to the personnel and manpower aspects of management. At the same time, they provide a necessary framework. Since the final responsibility for the provision of service rests at high levels of the profession, we think it would be quite wrong to transfer out of line management these functions on whose successful performance so much depends.

486. At Area Health Authority/Board level we propose that the team should include nurses or midwives who would have the status of Senior Nursing Officers. They would be specially trained in the manpower/personnel function and would be closely involved in the work of the specialised departments we have recommended. Such nurses and midwives should be responsible to the personnel officer for the day-to-day handling of their work but accountable to the Area Nursing Officer. We believe that needs at the District level would probably be best met in most situations by arranging the attachment of a personnel specialist from Area level rather than by creating a separate personnel department for the District.

487. There are at present very few people in the National Health Service, and even fewer in the nursing and midwifery services, who have received specialised training in personnel management. We have seen examples where appropriate structures have been created and appropriate staff appointed and they are beginning to make an impact. But the expected establishment of personnel departments in 1974 will create an urgent need for staff with the relevant expertise.

We recommend, therefore, that as a matter of urgency a substantial number of nurses and midwives, about a hundred in all, be trained for this purpose.

488. In order to maintain a regular supply of nurses and midwives to serve in this field, in the long term there will be a need for a regular training programme, perhaps involving study for the examinations of the Institute of Personnel Management, but in the immediate future it is a crash programme that is required.

LOGISTICS

489. Turning to manpower planning as an exercise in logistics, we start from the premise that it is impossible to devise sensible manpower strategies without defining and eventually, if possible, measuring "nursing and midwifery work to be done". At present, discussion and decisions about budgets and establishments start and finish in terms of numbers of nurses and midwives and numbers of hours, and there is usually, as we have seen, no separate consideration of the nursing and midwifery work that has to be done, of alternative ways of doing it to prescribed standards of performance, and of relative costs.

490. A new approach is necessary. It will be successful only if there is an adequate flow of information about nursing and midwifery work to be done from one level of nursing and midwifery to another. There are networks of responsibility. In the hospital sector, the Nursing Officer stands mid-way between day-to-day clinical work and the full-time management of resources, and in any new approach has a big role to play, especially in developing short-term manpower objectives and seeing they are met efficiently. (The corresponding function in the community sector is likely to develop at a slightly higher level.) Longer-term objectives require a more comprehensive view of nursing and midwifery and other resources, but the higher Salmon and Mayston grades are unlikely to succeed in getting the nurses and midwives they need unless they too can plan ahead in terms of the work to be done. Clinical assessment will have to be considered at higher levels than at present and the management function at ward or unit level will have to be extended.

491. A further outstanding deficiency of nursing and midwifery manpower policy at present is that there are no financial incentives to the "manager" to utilise manpower more efficiently. It is true that if a manager succeeds in cutting the budget (or adjusting to a budget which has already been cut by someone else), the consequent savings may be allocated to improving the working amenities of nurses and midwives. But there is no guarantee at all that this will happen. Managers may well hesitate, therefore, to put staff in the position of having to run faster in order to stay in the same place, particularly if they feel that the same financial stringency is not being applied to some of the other items in budgeting, such as expenditure on drugs or on specialised equipment required by consultants. The primary incentive for the nurse or midwife manager is the care of the patient himself or herself, and there must be enough information at the manager's disposal both to be able to bid for greater resources and to argue effectively with others about whether savings effected through better use of nursing and midwifery manpower are properly used if they are diverted to activities other than those of nursing and midwifery. We have noted the statements in the consultative docu-

ment on National Health Service reorganisation¹ that "the aim" is "to set clear objectives and standards, and measure performance against them". We interpret this as meaning that nursing and midwifery line managers have the definite responsibility to set objectives of care and levels of performance which are based on records of clinical assessment. Discharging this responsibility will mean that the approach set out in paragraph 490 must be followed.

492. While the direction of development is clear, the rate of progress will depend on the quality of professional leadership provided by the chief nursing officer of the Area Health Authority/Board (Area Nursing Officer) and of technical support from the new manpower and personnel departments which we are recommending at that level. Both will have a dual role in promoting new standards and services which can help nursing line managers at District level and below and in contributing to decision making at the Area level itself on such matters as budgetary allocations between Districts. These two roles need not conflict, provided that the lines of delegated responsibility are clearly drawn, and we welcome the emphasis in the consultative document on maximum delegation downwards, matched by accountability upwards. Delegation downwards means more than the recognition that those who are in direct contact with the patient must retain their freedom to make responsible professional decisions. It also provides great scope for an able Area Nursing Officer to enlarge that freedom through making new resources of knowledge, manpower, materials and money available at the places where they are needed most. Even more fundamentally, where the obstacles to freedom of responsible professional action lie in outdated custom and practice or the habits acquired through working over long periods in exceptionally adverse conditions, the Area Nursing Officer will have the task of demonstrating new opportunities in nursing and midwifery practice. This is a severe test of professional leadership and those who are seen to pass it will also be seen to possess those qualities which will make "accountability upwards" work. It is crucial, however, that this linking of delegation with accountability should be founded on mutual professional confidence. The Area Nursing Officer will have to be accepted both as a personal source of help within the profession and as a member of the inter-professional team who will have to make what often are necessarily hard decisions about the allocation of resources from the vantage point of the Area.

493. Accountability upwards is needed primarily as a basis for the making of these decisions and for the monitoring of the service provided. It entails regular concern with the assessment of performance in reaching clearly defined objectives. We do not think that skilled professional judgement can ever be excluded from such assessments or that such assessments can be made by people who are not nurses and midwives, and we wish to see much more emphasis given than in the past to explicit judgements about the quality of care which we defined in Chapter I as the objective of an integrated service.

494. We also wish to see the complementary development on a comparable scale of the collection and analysis of relevant quantitative information, and we consider next some needs which require a cooperative effort by nurses and midwives in line positions and by the new manpower and personnel departments.

¹ See list of references, no. 29.

495. The first need, however difficult it will be to meet, is to develop measurements of the "output" of the nursing and midwifery services in a form which satisfies the criteria. One is that it should be possible to speak of the objectives of a particular unit or sector of the services in terms of "target levels" of their outputs. The other is that it should be possible to compare over time measurements of output of different units or sectors or their subdivisions.

496. Simple measurements of output are already available in the records of the number of patients treated, but these are a poor guide to planning, even in a small and well defined unit, unless they are supplemented by data on the quality of care achieved. The point has already been made in the discussion of "shortages" that too little attention is paid to quality as opposed to quantity, and the setting of objectives in terms of case-loads at clearly defined levels of quality of care is essential if nursing and midwifery management is to overcome the sense of shortage. It is only against such data that the adequacy of staffing levels can be assessed and the costs of alternative mixes of staff can be evaluated. Some variations in costs may be entirely legitimate because of variations in local labour market conditions: others will clearly not be.

497. We envisage data on output being collected initially for the better day-to-day management of resources at the working level, but the data will be needed also by the Area Health Authority/Board which will be planning for the Area as a whole. There will be some general problems of nursing and midwifery manpower shortage which can only be solved by inter-professional decisions at that level. In particular, guidelines will be needed from the Area Health Authority/Board on the contribution which trained nurses and midwives should make in relation to their other colleagues in the health team (for whom effective placing is equally necessary) and on the educational demands of nurses and midwives who are still in training. We have seen many examples of nurses being drawn into non-nursing jobs through the absence of other staff and have noted that in midwifery, where borderlines are more clearly drawn and objectives better defined, the manpower problems are generally less acute. We do not think that nurses should continue to be regarded as a residual group who can be regarded, because of their large numbers and twenty-four hour service, as being available to fill whatever gap appears in the health care system. In addition to setting guidelines on inter-professional boundaries, we recommend that Area Health Authorities/Boards, in consultation with the Colleges of Nursing and Midwifery, set guidelines on the use of trainees for service work within nursing and midwifery teams.

498. A second joint contribution from the new manpower and personnel departments working with line managers would be to monitor performance in the service. The essence of performance monitoring is that decisions about resources should be related directly to clinical objectives, with greater attention being paid to quality and more effort being made to assess the value in terms of patient care of competing claims on expenditure. Of course, as we have seen, it is difficult to measure quality in nursing and midwifery, but a certain amount of relevant information is already collected in some of the most progressive hospitals. An unsuitable mix of staff, low levels of coverage by trained staff, performance of more technical duties by untrained staff and the organisation of shift systems all carry significance for the quality of work done. Performance monitoring will also involve collection of data on workloads. On the basis of these accumulated data

it should be possible to make decisions both on an annual and on a longer-term basis which will pay proper attention to patient care. Such an approach would be very different from that generally used now in setting establishments and in allocating budgets. We do not see any conflict here with the work of the Hospital Advisory Service, which will continue to provide a stimulus, although not on such a day-to-day basis, and to spread good practices.

499. A third need is for the provision of new management services by the Area Health Authority/Board. Such provision will be the primary responsibility of the manpower and personnel departments, the functions of which we now examine more fully. As one of their first tasks we would expect to see these specialist departments giving the lead in the development of the extended information system described above dealing with other categories of staff as well as nurses and midwives. Within the nursing and midwifery profession itself much more needs to be known on a regular basis not only about the numbers and the sources of recruitment, but also about the characteristics and behaviour of the work force. We need to know more about the "internal" labour market and, not least, more about the pattern of turnover and recruitment difficulties for particular grades or types of skill. At present we have an abundance of "moment of time" data but little information on flows, the pattern of stability and movement between sectors of the National Health Service, and into and out of the service.

500. The Health Departments, the central training bodies and regional and Area authorities should cooperate to devise a comprehensive information system, and the existence of personnel/manpower departments at regional and Area level together with the more concentrated administrative structure for nursing and midwifery education which we are suggesting should facilitate collection. The fact that by and large each level in the service needs the same kind of information is an advantage in working out a system, although it could be needed in different degrees of detail at different levels. In Appendix I we give examples of the kind of statistical information which in our view would enable key questions to be answered.

501. It would be for consideration how far such information would be needed on an annual basis at each level and how far some of it could be collected on a sample basis or at less frequent intervals. The important need is for a systematic approach to enable manpower and personnel policies to be regularly reviewed and updated. We understand that the Health Departments are already making preliminary investigation into such information needs and the ways and means of collecting data of this kind, including the consideration of how much may be obtained from standardised computer payroll records. We welcome such developments. We see a need also, both for local management purposes and for higher level strategic planning, to conduct from time to time opinion surveys on how nurses and midwives personally conceive of their jobs and conditions of service. These would follow on naturally from the surveys which we instituted ourselves and would enable comparisons to be made at different points in the process of integration.

502. There would be much to be gained by involving in the process we are outlining specialists in labour economics, operational research and statistics as well as personnel management, including industrial relations. Some such expert

resources are already available centrally and at some Regional Hospital Boards, and we know of instances where such knowledge has been employed in the planning of community nursing.

503. Another function of the new departments would be to devise local recruitment policies and to provide guidance on such matters as the effective use of part-time staff, the organisation of shift systems, staff representation and the provision of residential accommodation. Our studies suggest that there is a need for each Area Health Authority/Board to evaluate carefully the groups which are most favourable from the recruitment point of view, the best methods of reaching them and any special incentives required to attract them. In some parts of the country school leavers may be the most promising group, in others older married women. Different methods of reaching potential recruits may be effective in different Areas. In some, advertising in local newspapers may be the answer, in others, more personal methods of approach. Authorities with recruitment problems can offer a variety of special incentives to potential recruits. These include the provision of day nurseries and of transport and the running of special back-to-nursing courses. Choices between alternatives tend to be taken at present by rule-of-thumb methods, and the new departments could be of great help in weighing up the costs and benefits of alternative approaches.

504. A personnel officer could also help in the organisation of shift systems to fit new recruits. Too often authorities take a discouraging attitude to part-timers, or, at the other extreme, full-time staff bear too large a burden of the unpopular hours. Personnel staff could help to prevent these undesirable developments and show how part-time staff can be used effectively. Hospitals will have access to national information, which at present is often inadequate, showing, for example, how twilight shifts and permanent night shifts have proved attractive in some areas. Personnel departments could also help more generally with the improvement of staff conditions. The need is for enlightened manpower policies at both District and Area levels.

505. There must also be regular liaison on recruitment and matters relating to conditions of work between manpower and personnel departments and the Colleges of Nursing and Midwifery which we recommended in Chapter IV. Guidance can be given to Area Education Committees by the personnel departments on the means of reconciling service and education needs within the national framework.

506. It should also be a responsibility of the manpower and personnel departments to develop manpower forecasting techniques as an aid to decision making. This is a difficult area of research, where progress during recent years (not only in relation to nursing and midwifery) has been disappointingly slow. We have deliberately refrained from making any forecasts ourselves because we believe that bad forecasts may be a worse basis for planning than none at all. This may be particularly so if attempts to achieve "targets" distract the attention of policy makers from the need to develop planning and educational systems which are sufficiently flexible to meet the uncertainties inherent in a changing and developing National Health Service.

507. Provided such limitations are recognised, however, we see considerable scope for the development of simple forecasting methods during the next few years. We believe that the development of more sophisticated methods should focus not on the forecasting of the numbers themselves but on the future form of the relationships which link the numbers together, such as the relationships between manpower and other inputs into health care on the one hand and measurements of output on the other. In our view the choice of one set of numbers rather than another is properly the responsibility of planners and managers. It should be possible eventually to develop models of the flow of nursing, midwifery and other manpower through the National Health Service. These would incorporate data on recruitment, deployment, mobility and wastage, would provide a better basis for the assessment of likely future resources and would indicate the points of weakness in the system which manpower and personnel policies should seek to remedy.

508. Two related areas of research should also be the concern of the manpower and personnel departments:

- (a) the economics of nursing and midwifery manpower utilisation; and
- (b) the identification and promotion of changes in working methods by organisation and methods study and related techniques.

509. By the first, we mean that there should be detailed analysis of, for example, the costs and benefits of using particular numbers of nurses in, say, out-patient departments as compared with using them in other nursing units. There may often be a justification for using manpower in high-cost ways, but it would help to restrain those uses which merely express the continued application of outdated custom and practice if both the costs and the justification for them were made explicit. Moreover, not all the problems worthy of study are the residue of history: some will be new problems associated directly with the moves towards integration when alternative forms of nursing and midwifery utilisation will have to be considered *de novo*.

510. Turning to the promotion of improved working methods, we believe that at present the nursing and midwifery profession puts too little effort into organisation and methods study and the discovery of better ways of carrying out routine procedures and of collecting routine information. There is a wide disparity between the potentiality of nurses and midwives to initiate significant improvements in practices and their actual achievement in doing so, and what passes as innovation in nursing and midwifery procedures at ward level, for example, is all too often a hasty improvisation in response to an initiative taken, without adequate consultation of nurses or midwives, by somebody else. We urge the manpower and personnel departments to give a lead in trying to close this gap by making available a wide range of management services and by demonstrating the contribution which such services can make. One suitable case for study, directly related to the line of argument in this chapter, concerns the frequency of demands for information made on nurses and midwives considered against the use actually made of such information and its likely reliability having regard to the working conditions under which the demands have to be met.

511. Finally, we stress the need for the manpower and personnel departments to organise and maintain a management development programme for nursing and midwifery. The National Nursing Staff Committee and the Scottish Nursing Staffs Committee with their selection and appointment procedures, their appraisal schemes and their management training programmes have already made good progress in this direction for hospital nurses and midwives and somewhat similar developments are now being planned for community nurses and midwives. But there will be a need for more far-reaching and comprehensive policies, continually kept under review, in the integrated service of the future. The quality of that service must depend heavily upon the quality of its management. We discuss elsewhere some of the needs in this respect. Some require arrangements specific to nurses and midwives, others, such as management training, need a multi-disciplinary approach.

NATIONAL MACHINERY

512. Within the system we propose, the manpower and personnel groups in the Health Departments have a crucial part to play. They must concern themselves with the development of strategies relevant to the needs of the service as a whole and covering the whole range of staff. They should not sit in isolation carrying out statistical exercises, whether in forecasting or in any other field. While they will be in a special position to initiate and develop certain research projects, they must be an integral part of the top management team and must work in close consultation both with representatives of the public and with those responsible within the National Health Service for pay and conditions of service, training and other personnel matters. They must be willing and able to set objectives, to plan and check performance and to revise objectives, when necessary, in the light of experience. They must also be able to consult fully with other Government Departments concerned with manpower planning in relation, for example, to graduate employment or the provision of common social facilities for married women returning to work. Among the specific tasks we envisage for them are planning for the balance of the National Health Service labour force as a whole, monitoring shortages by collecting information on standards in patient care, changes in the mix of staff, difficulties in local recruitment, shortages of supporting staff and cover by qualified nurses and midwives at night, monitoring differences in the levels and mix of staff between Regions, carrying out forecasts for the staff required in specialist units and spotting good practice and promising innovations. We welcome steps taken recently to reorganise the Health Departments and the proposal to create central advisory machinery on personnel and manpower matters.

513. In Scotland and Wales we would expect there to be close ties between those responsible for personnel and manpower work at central and local levels. But in England, where because of its size there are to be some fourteen Regional Health Authorities carrying out what might be described as an extension of central functions, there will be a need for the central manpower and personnel departments to concern themselves with the implementation of national strategies within their Regions. They will also have to secure adequate coordination between Area Health Authorities/Boards, the boundaries of which will not necessarily be natural ones for manpower planning purposes. We have seen some such departments in their embryonic stages at a few Regional Hospital Boards: they have already confirmed the need for such support to line management.

514. Because of the research involved, the development of personnel management and more especially manpower planning is a long term goal. In the interim, we think that much can be achieved by the setting, by both the Health Departments and Regional Health Authorities, of minimum staffing ratios. This is now being attempted, somewhat crudely, in the fields of mental handicap, mental illness and geriatric nursing. In December 1969, as part of an overall programme of interim measures to improve services for the mentally handicapped, the Department of Health and Social Security¹ asked hospital authorities to plan to achieve a minimum staffing ratio of not less than one nurse to 4.4 staffed available beds (exclusive of allowances for sick and annual leave and training time). In a similar programme to improve standards in mental illness and geriatric hospitals and departments, the Department¹ in March 1972 asked hospital authorities to aim to reach by the end of 1974 minimum standards of one nurse to three in-patients and one nurse to 1.9 in-patients respectively (both inclusive of leave and training allowances). The minimum standards set in the latter two types of hospitals and departments were roughly estimated to equate to the national averages in such hospitals in September 1971. This is a useful beginning and we recommend that similar procedures should be extended immediately to other areas of nursing as an interim measure and that more detail be introduced into the system. We also recommend that studies should be made immediately of the staffing problems of specialised units, such as intensive therapy and renal dialysis units, on which we have commented earlier.

PLANNING AND BUDGETS

515. The budgetary system is of crucial importance both to a realistic setting of minimum standards in the short run and to any long-term major exercises in setting objectives. The point has often been put to us that the primary constraint at present on improving the position in under-privileged areas is lack of manpower rather than lack of funds. The point cannot be dismissed, particularly in relation to places which, like many psychiatric hospitals, are inappropriately sited or in places where there are too many hospitals competing in the same area for staff. In the absence of fully developed manpower planning and personnel management machinery, we do not believe, however, that the point is generally true: in fact, we have seen instances where dramatic improvements have been effected following concerted efforts even in most unfavourable circumstances. We have also seen many instances where the nursing and midwifery staff position has not been taken into account before setting up new services, such as special units, or when developing existing ones on a new scale. Examples have been brought to our attention of cases where the reorganisation of administrative arrangements (for example, the joint planning of hospital admissions and staffing policies to cover several wards) can make for more effective use of existing resources. Attachment schemes which involve joint planning between the community nursing and general practitioner services are another example. It is for reasons such as this that we place so much emphasis on multi-disciplinary planning and the determination of specific objectives after correlating ascertained needs and staff resources.

516. Whatever improvements can be effected through the existing system, we conclude that there is scope for more discriminatory budgeting than there is at present. Allocations of funds to the hospital service have followed a pattern of uprating from the base that existed in 1948, and within such allocations each

¹ Parallel action was also taken by the Welsh Office.

department of a hospital has had to make the best bargain it could. Until about 1960 the new money available each year for hospital revenue allocations was insufficient to make a significant difference in the comparative levels of allocations existing from 1948; with the introduction in 1962 of the "Forward Look" estimating system it began to be possible to calculate annual revenue allocations with a view to equalising eventually the financial position for all Regions. Recently this programme has been accelerated by the introduction of a revenue distribution formula based on the size of population served, the number of beds in use and the number of cases treated. This is helpful, and efforts to refine the formula to take account of relatively minor elements are continuing. Nevertheless, under the formula equality of provision is not envisaged until about 1980. While comparatively large differences in provision continue, allowance cannot properly be made for minor differences such as an above-average reliance on part-time staff, the use of whom would be extended in some places if our recommendations were to be adopted, thereby entailing greater overhead costs.

517. In the long run, budgetary procedures must become somewhat more discriminating as the service moves more towards management by objectives. We welcome, therefore, the feasibility studies on Planning, Programming and Budgeting and Departmental Accounting which are at present in progress. We have noted that specific allocations have recently been announced for services to the mentally handicapped, the mentally ill and the elderly, and see great and immediate value in such specific additions to help overcome identified problems in the service. In fact, since there are only limited possibilities of reallocating resources within their existing level of provision, it is in the judicious use of whatever extra financial resources are made available that the biggest impact can be made in the fields of greatest difficulty. Searches for economy should of course be continuous and savings should be applied to the most deserving fields. As a key management level the Area Health Authorities/Boards must discern changes in needs and priorities and relay the information to the regional and national levels. This feed-back of information from the Area level is vital here.

518. The setting of objectives should be of considerable value to the community nursing services. Hitherto the activities of community services have been determined by the financial policies of a large number of local authorities and they have had to contend with many other major services when making their case for resources. The position will change with the development of Area Health Authorities/Boards responsible for an integrated National Health Service.

WORK FORCE AND PROFESSION

519. The strategy we have advocated in this chapter depends on the willingness of nurses and midwives to work with others. Nationally, in particular, some of the necessary research projects and information processes we have advocated concern the National Health Service as a whole, in some cases even more than the National Health Service. We would like to draw attention to the fact that it is precisely these cross-professional problems, which seldom come before an independent committee, which are frequently the most important ones and those to which manpower economists and the other social scientists can contribute most.

520. We would emphasise in conclusion, however, that policies for nursing and midwifery, including planning at the national level, cannot be evolved without

the involvement of nurses and midwives at each appropriate level. Given the need for expert support from social scientists set out in paragraph 502 and noting the important operational role of aides in the nursing and midwifery work force, we recognise that nursing and midwifery is more than a work force. It is a profession, and creative concern for developing professional standards in a changing society can itself be a powerful lever of change. In a profession, as we were told by one of our witnesses, "the performance and carrying out of professional activities must be founded on an understanding of the nature of the things involved in them so that the results of professional actions can be foreseen. The antithesis is an occupation based on customary activities and modified only by trial and error, not by understanding and reason". This chapter is an appeal to understanding and reason. "A profession", the same witness went on, "needs a special and unusual competence because it is concerned with vital needs. . . . Competence is not enough: there must be a continual striving after excellence." We are in full agreement with this conclusion.

CHAPTER VI

OPPORTUNITIES, CAREER STRUCTURES AND CONDITIONS OF WORK

ATTITUDES TOWARDS PROMOTION

521. In Chapters IV and V we have set out our views and proposals on education and on the use of resources. In any profession it is obviously vital to the successful resolution of problems in both these areas that the structure of the profession is correctly designed and that the environment is such that the implementation of new policies is eased rather than hindered. In this chapter we deal first with career structures and second with conditions of work.

522. Nurses and midwives enter the profession to care for people, but for reasons described in Chapter II, they sometimes find themselves carrying out a variety of tasks very different from those which they first anticipated. Sometimes their abilities are stretched as their horizons are widened. Sometimes, however, they are employed in circumstances where they can neither fully employ their skills nor express their interests. Given the introduction of the new educational pattern which we are proposing and the moves towards integration of health services which are accepted national policy, we believe that the profession is capable of attracting a wider range of recruits and should offer them a more clearly defined set of career opportunities.

523. In Chapter II we quoted junior nurses and midwives and nurses and midwives in training on their immediate reactions to their work, and we noted that despite the difficulties there was a genuine sense of involvement. Looking at the structure in terms of experienced nurses and midwives, we share the view of the Salmon Committee¹ that senior nursing and midwifery posts, which are of key importance in relation to the future of the profession, should be made attractive and satisfying and the structure of the profession as a whole should be as simple as possible so that nurses and midwives can plan their careers more easily from the start.

524. We tried through our surveys, which covered both hospital and community nursing, to discover the attitude of nurses and midwives towards promotion, assuming at the start of our enquiries that only a minority of entrants to nursing and midwifery are "career minded". Our surveys showed that:

- (a) around half of those nurses and midwives not currently in training are happy to remain in their present grades. There appears to be a substantial group with little desire to take on new and different responsibilities;
- (b) fifty-one per cent of student nurses desire ultimately to become ward sisters, much the most popular grade. So do thirty-two per cent of pupil nurses;
- (c) nurses and midwives as a whole, even registered nurses, do not aim straight for the top, even if they wish eventually for promotion. They are very

¹ See list of references, no. 79.

cautious about grades above the rank of sister/charge nurse, probably not considering these grades to be involved in direct nursing of patients;

- (d) junior nurses are ready to opt for posts above their ceiling. Thus, fifteen per cent of auxiliaries and assistants want to be enrolled nurses; thirty-two per cent want to be either a staff nurse or a sister or above; thirty-eight per cent of enrolled nurses want to be a staff nurse or above; twenty-five per cent of enrolled nurses want to be a sister or above.

525. A general statement about the attraction of senior grades was put to nurses and midwives in our postal survey. About half of all respondents agreed with the statement that “administration and training of nurses are less satisfactory than direct patient care”, but few agreed strongly. Those already in senior positions were naturally less likely to agree, but around a third did so. Differences within other grades were small.

526. Our postal survey showed further that large numbers of nurses and midwives are not expecting—or looking for—promotion during the next two years, though there are marked differences in response by grade. Students and pupils both tend to expect promotion—not surprisingly, as this will follow qualification. On the other hand enrolled nurses and auxiliaries and assistants—groups with limited or no promotion prospects—tend to expect to stay in their current role. Senior nurses and midwives already having experience of the profession at different levels are more likely than most to expect further promotion:

TABLE 45

PROSPECTS IN TWO YEARS' TIME AS SEEN BY
HOSPITAL NURSES AND MIDWIVES*

	Sisters		Staff nurses		Enrolled nurses		Assistant and auxiliary nurses		Midwives†	
	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time
Base:	905	147	508	585	763	481	529	1028	346	105
	%	%	%	%	%	%	%	%	%	%
The same job	60	67	22	56	62	78	72	81	28	64
Similar job in another hospital	9	9	13	8	11	4	3	2	11	4
Higher grade in a hospital	14	—	31	7	8	2	7	3	28	5
Local authority nursing	1	4	6	4	1	1	—	—	8	2
Another nursing job	5	4	13	7	8	3	4	2	15	6
A job outside nursing	2	1	4	1	2	1	4	2	3	2
No job at all	9	12	9	14	6	7	5	5	4	16
Don't know	2	3	2	2	2	2	6	5	3	2

Source: Postal survey.

* Columns may not sum to 100 due to rounding.
† Includes pupil midwives.

527. Further analysis of the responses shows that:
- (a) the larger the hospital, the more likely the nurse or midwife is to expect promotion;
 - (b) the smaller the hospital, the less likely it is that its nurses and midwives will still be working in the team where they started;

- (c) part-time nurses and midwives do not expect promotion; most of them think they will stay as they are;
- (d) nurses and midwives who have had a gap in their careers during which they have not worked at all tend to expect to remain in their present post, rather than be promoted. But those whose only gap has been filled by another job are not so pessimistic about their chances;
- (e) the same proportions of male and female nurses expect to hold their current position in two years' time. But of those who do not, male nurses tend to expect promotion more than women;
- (f) community nurses and midwives are distinguished from hospital nurses and midwives mainly in that they mostly expect to remain in their present posts for at least two years. But their seniors, as in the hospitals, tend to look forward to a higher grade.

528. We were not surprised at these results. A recent survey¹ of women office workers showed that only fifteen per cent of women mentioned promotion prospects as a factor influencing job choice and in a Location of Offices Bureau survey², whereas sixty per cent of men mentioned promotion prospects as a factor, the comparable figure for women with children was fourteen per cent.

529. We also asked all nurses and midwives to state how good they considered promotion prospects to be for their colleagues at their level. Half the hospital nurses and midwives and almost two-thirds of the community nurses and midwives rated prospects as being "not very good". Senior nurses and midwives were more optimistic than other grades, but about a third thought their prospects "not very good". About three-quarters of enrolled nurses and assistants/auxiliaries and over half the pupils thought their prospects "not very good". District nurses, followed by midwives and "others" were most pessimistic among the community nurses. We would expect as the Salmon and Mayston structures develop and an integrated service is introduced, existing jobs may offer a wider range of satisfactions, and at the same time new avenues will open to improve promotion prospects and job satisfaction.

CURRENT STRUCTURES

530. There remains much misunderstanding, even in knowledgeable circles, of certain aspects of the Salmon structure, and of the consequences of its implementation. For example, it is often said that following the Salmon Report³ the number of administrative posts in nursing and midwifery has increased, that the scope for clinical career advancement has been reduced, and that the best nurses and midwives are being drawn away from the ward situation thereby lowering standards of patient care. In fact, statistics collected in relation to the Salmon pilot schemes reveal that in almost all cases there are now more ward sisters, charge nurses and staff nurses in proportion to nurse and midwife administrators (i.e., Nursing Officer and above) than there were before. In creating the post of Nursing Officer, the Salmon Committee considerably increased the number of more senior posts where nurses and midwives can use their professional experience directly, thus reducing the old dichotomy between clinical and administrative

¹ See list of references, no. 2.

² See list of references, no. 63.

³ See list of references, no. 79.

work. The Nursing Officer post is often a combined clinical/managerial post and there are now significant numbers of Nursing Officers carrying out jobs with considerable clinical content.

531. We recognise in this context that those posts based on geographical as opposed to functional units sometimes seem less attractive because of the difficulty of exercising clinical expertise over a number of specialties. Yet with the work of the night superintendent, for example, this difficulty is not a new one. The Salmon proposals were designed not to create a top-heavy but a more satisfactory administrative structure in terms of providing better support for those actually caring for the patient in the ward or department and ensuring better management of nursing and midwifery resources. We have noted some of the early favourable comments on them in professional journals: one of them¹ stated, for instance, that "it need not be long before the Salmon structure could be in full swing and the present rigid and authoritarian system merely a hideous memory".

532. The real benefits of Salmon are only just beginning to appear now, when the early and necessarily sometimes uneasy stages of implementation and assimilation are complete. Only now can people begin to stand back, define their real objectives and plan accordingly.

533. The pattern in community nursing and midwifery is changing also, as we pointed out in Chapter I. The change has been much accelerated by the Mayston Working Party's report² which put forward proposals in some detail for the establishment of a management structure in community nursing and midwifery designed to promote effective deployment of nurses and midwives, to provide more precise and satisfying career opportunities, and to ensure compatibility with hospitals. In August 1970 a circular³ was issued by the DHSS to all local health authorities asking them as a matter of urgency to review the senior nursing and midwifery staff structure in their area in the light of the Working Party's detailed recommendations and to report to the Department on action taken or proposed. At 24 May 1972 out of a total of 157 local health authorities in England (excluding the Isles of Scilly) 132 local health authorities had a Director of Nursing Services in post, 112 had agreed to restructure their nursing services and seventy-six had introduced a new structure, fully or in part. The introduction of this new management structure in the local authority nursing and midwifery services has created few problems. At least half of the local health authorities had already appointed a Chief Nursing Officer to coordinate the nursing and midwifery services prior to the Mayston Report. In some instances, the pattern of nurse and midwife management in the community was similar to that recommended in the Working Party report. In other authorities, however, some readjustment has been necessary, particularly in areas where there has traditionally been a separate development of health visiting, home nursing and domiciliary midwifery. In general the change to a largely geographical pattern of management has been undertaken smoothly.

534. In some areas, however, confusion has arisen because the responsibilities of field workers in the community are more nearly akin to those of ward sisters in the hospital context: their pay spans the staff nurse/ward sister range, and first line management in the community services is comparable to lower middle

¹ See list of references, no. 96.

² See list of references, no. 39.

³ See list of references, no. 28.

management in hospital. The basic field workers in the community (the health visitor, the district midwife and the district nurse) are not only required to make decisions on their own initiative, but at the same time have managerial responsibilities for staff working with them in a supporting role.

535. First line management in the local authority service is management of field workers. At this level of management the professional element predominates, and it would be unusual for first line managers to control field workers in disciplines other than their own. The first line managers act as consultants in nursing or midwifery practice and promote the development of new ideas and methods in the units. They are responsible also for the coordination of work of the field workers in their charge, provide a focal point at their level in the lines of communication and control, and offer support for middle management.

536. The introduction of the Nursing Officer post (first line management in the community) has created an additional clinical level and this appears to have awakened the interest of many community nurses and midwives in promotion. It has certainly proved reasonably easy to make appointments to new management posts where, in the past, senior posts have remained unfilled for some time. This is both a measure of the acceptance of the need for the new level of management and a recognition that there must be clinical involvement for nurses and midwives not working in the field at the basic level.

537. General agreement was expressed by nurses and midwives in our survey that there ought to be more information available for nurses and midwives who want to further their careers either in hospital or community nursing and midwifery. We regard career guidance as an important function of Colleges and of personnel departments as well as of line managers. At each stage in their careers, nurses and midwives must be able to feel that there is someone to whom they can go for advice about the next step in their professional development. Nor should the initiative lie solely with the individual. Guidance should be offered and not merely be available on request. Graduates entering the profession have special needs: so, too, at the other end of the spectrum do nursing aides who may have the desire and the ability to enter the profession.

538. We have carefully considered the range of career opportunities in the hospital and community health services in the light of our approach to patient needs and to the strategy of integration:

- (a) we are uneasy about sharp distinctions between clinical, managerial and teaching responsibilities since, as we have argued, first, there are managerial and teaching elements in the role of all nurses and midwives who have finished their training and second, the most senior administrative and teaching posts should be held by people with initial clinical experience, who will exercise continuing clinical judgement;
- (b) the tendency within the profession to think in terms of Salmon grade numbers is natural and follows from the attempt to introduce an analytical and objective approach to staffing structures. Yet unless the principles underlying the division between grades are clearly understood inside the profession, it will not be possible for the profession to communicate clearly with a general public which does not think in terms of grade numbers;

- (c) job descriptions cannot usually be prepared in detail nationally because local circumstances vary considerably, but, as has been found in the implementation of Salmon pilot schemes, outline job descriptions are useful and can and should set out definite objectives;
- (d) in the development of the service there should be opportunity for discussion, presentation of different points of view, and change. Perceived needs should count for more than preconceived patterns, and there should be opportunity for such needs to be identified at the team level.

ELEMENTS IN THE STRUCTURES

539. We have built up our own ideas about structure not from above but "from below". We have abandoned the fundamental distinctions between student and pupil nurse and registered and enrolled nurse which we believe to be harmful to the future of the profession and substituted the idea of an open career in nursing and midwifery following on from Certification which will be the basic qualification for all nurses and midwives.

540. In the work situation, where we start, we emphasise the need for the patient to be the focus of care provided by teams whose members will work in cooperation with one another, and we set out some of our main ideas about the team in Chapter II, paragraphs 122-137. Each team would include some or all of the following: qualified nurses or midwives at both basic and higher levels, full-timers and part-timers, learners in designated training areas and aides. In the hospital context, senior staff nurse posts and ward sister posts should be open both to Registered nurses (with or without a Higher Certificate) and where appropriate to basic Certificated nurses of long experience and proven expertise. The role of the leader of the community nursing team would, like specialist hospital nursing or midwifery posts, normally call for studies carried beyond basic level.

541. The organisation of work at ward and field level and the respective responsibilities of senior staff nurses and ward sisters have also been discussed in detail in Chapter II. Coordination of the nurses working in the ward and responsibility for setting work objectives will be exercised by all ward sisters. Ward sisters will also have a clinical teaching function and they will all need to liaise closely with the teaching staff (see Chapter IVB, paragraphs 353 and 356). Yet ward sisters are not a homogeneous group. Some will bear a heavier degree of responsibility than others, and there will also be differences in knowledge and experience. Ward sisters of higher clinical skills, often in specialised fields, may already exercise advisory functions to other nurses and members of other professions, and this kind of development should be encouraged. As integration proceeds, the "consultancy" function, as we call it, should extend beyond the boundaries of the hospital. Similarly, some ward sisters will and should have and exercise clinical teaching skills to an above-average extent. Some ward sisters will play an active part in the important and growing field of clinical research.

542. In our view, recognition should be accorded to exceptional abilities and multiple responsibilities, and we recommend that some ward sisters, by virtue of proven expertise linked with other functions of the kind described, should be accorded increased status and reward within the line structure. This increased status and reward should be secured either by an extension of the existing concept

of the role of the Nursing Officer, discussed in more detail below, or by appropriate recognition of special services within the ward sister grade.

543. We regard the post of Nursing Officer as being of great importance in relation to the future of the service. Nursing Officers have access to ward knowledge and research and through the coordination of the work of wards within a unit are in a strong position both to initiate change and to communicate change to others. They have a wide range of opportunities for the exercise of clinical expertise as well as management skills. We recognise, however, that where a unit is made up of wards in a variety of specialties, the Nursing Officer cannot be a clinical expert in all of them. Too often the Salmon proposals for this grade have been interpreted rigidly. We see scope, therefore, for development of a range of roles for Nursing Officers, with the emphasis on different aspects of their total range of functions according to the post held.

544. The units of which they are the leaders should be flexibly conceived and may consist of a great or small number of wards depending on patient dependency and other factors. In certain circumstances, as was suggested in paragraph 542, a unit could be one specialist ward (for example, in ophthalmology). Where possible, wards should be grouped functionally, although we recognise that this will not always be feasible, for geographical reasons. Given the integration of services, the unit with which the Nursing Officer is concerned could include community and/or teaching responsibilities.

545. The preceding paragraphs deal with an extension of the functions of nurses and midwives at ward and unit level within line management. At levels equivalent to these and higher grades, we envisage an increased part to be played by nurses and midwives acting in a staff capacity outside line management, carrying out functions in relation to, for instance, personnel and, an important growth area, clinical, operational and other kinds of research. Many of these posts would cross hospital and community borderlines, and there should be freedom of movement between clinical, educational and other areas as required by the work in hand. For most nurses and midwives, these staff posts would be, not a career in themselves, but part of a career moving in and out of line management and (a separate subject which we develop later) teaching.

546. Before turning to the nursing and midwifery staff structure beyond ward and field level, it is appropriate to extend what we have said about ward and unit staff by examining the structure and functions of the fieldwork team in the community. The direct patient care team will in most cases continue to be based in either hospital or community for the foreseeable future. There will be exceptions, of course, to this; in particular, midwifery is a field in which teams are already beginning to follow patients across traditional boundaries and provide comprehensive care from a unified base. Similarly, hospital nurses are becoming increasingly involved in psychiatric after-care and community nurses are developing close links with local hospitals. We believe that the integration of the National Health Service will have important long-term effects and will encourage the development of liaison as a function of all nurses and midwives. For some, following the pattern of the present geriatric liaison health visitor, for example, liaison will be a major function. We welcome such links wherever established, along with growing communication and interchange, but it would be unrealistic

to expect an immediate dramatic change in traditional patterns of delivering direct care, even if this were feasible or desirable. Hence paragraphs 541-544 above refer to nurses and midwives involved in direct patient care in the hospital setting, while those which follow relate to nurses and midwives delivering direct care from a community base.

547. In the community, as in the hospital, structure must reflect function. We propose to deal with this question in some detail in relation to the community, because it became evident to us in the course of taking evidence that strong and divergent views are held about the future of nursing in this field. Our own views are based on our assessment of developing needs in the community. We believe that the community health services, when considered as a main element in an integrated National Health Service, will have the following needs, some related to the positive promotion of health, some related to the actual provision of health care, except where admission to a hospital is essential:

- (a) a preventive health care service, including the development of presymptomatic screening;
- (b) the health supervision of children under school age and school children until they leave school. The role of the school health service is moving away from the provision of routine medical examinations of all school children to an assessment of their health and welfare and how they function in school. Health visitors, or in future family health sisters, will be in touch with the child's development in nursery care and at school. They will be able to participate, therefore, in the on-going assessment of children, including the handicapped, and their existing link with the home and school will need to be supplemented by closer liaison with the hospital services;
- (c) developmental paediatrics and the early ascertainment of handicap, physical and mental;
- (d) the ascertainment and provision of necessary health care and attention for families at risk;
- (e) care for the chronically sick, handicapped and disabled, particularly those living within the community, and the tendency to shift the burden of care away from hospital to the community. While the bulk of supportive care will fall to the social services departments of local authorities, family health sisters will also find themselves concerned in patient and family support. Family clinical sisters will be involved when disabled patients living at home are in need of nursing care;
- (f) the treatment and care of the mentally ill and the frail elderly, both of which groups are intended to become increasingly community- rather than hospital-based;
- (g) the development of public understanding and support of community health measures and environmental hygiene. There is a growing realisation of the importance of health education. Twenty years ago, the main concerns of the health visitor were ante-natal and child care, the prevention of home accidents and advice on immunisation, diet, hygiene and infectious diseases. Today, the health visitor is required in addition to advise on family planning, care of the elderly, cytological testing and other aspects of cancer, drugs, alcoholism, mental breakdown, sexually transmitted diseases and

dental hygiene and an ever-widening range of other activities. To achieve maximum effect much of this health teaching will continue to be undertaken in the home on a personal basis and increasingly through groups in health centres;

(h) cooperation in domiciliary family planning services.

548. Staffing patterns and career opportunities in community nursing and midwifery must be related to this list of needs. We believe that there is a continuing demand in community nursing for the qualifications and experience of both the present health visitor and the home nurse and for higher levels of skills in both disciplines:

- (a) family clinical sisters in the community (Registered and with a Higher Certificate in community clinical nursing) will have a wide range of duties, starting with the provision of skilled nursing care to patients in their own homes, in group practice premises, health centres, surgeries and elsewhere. They will work with general practitioners during surgery hours, assisting with diagnostic services, minor surgery or first aid/accident work. They will undertake nursing treatments for ambulant and other patients and any follow-up treatment of patients discharged from hospital. In the provision of nursing care they will make full use of available nursing aids and equipment. Their work will be related to virtually every medical specialty;
- (b) family health sisters (Registered and with a Higher Certificate in community preventive nursing) will perform a range of functions in the areas of case-finding, support counselling and health education. They will visit the new mother and baby as soon as the special skills of the midwife are no longer required and undertake supervision of all children both at home and at school, where they will be responsible for medical and hygiene inspections and screening tests, and participate in immunisation programmes and teaching on health matters. They will have an important role in the provision of family planning advice. They will provide health and nursing support for the chronic sick and handicapped in the community who do not require clinical nursing. In this work and in meeting the needs of those mentally ill and handicapped who are being cared for by nurses in the community they will cooperate with workers in the personal social service departments. They will help the elderly and their families to understand the normal physiology and psychology of old age and ensure that adequate support is provided to help the elderly remain independent. They will provide health education in the home and elsewhere on all relevant topics. In these and other spheres of activity family health sisters will play an important part in the positive promotion of health;
- (c) in rural or isolated areas there will continue to be some nurses with a combined preventive/clinical qualification;
- (d) the family clinical sister, the family health sister or the nurse with responsibilities in both fields will be supported by a nursing team which may include Registered and Certificated nurses, nursing aides and students gaining community experience;
- (e) where circumstances require that a midwife is based in the community, she should also where feasible be part of the primary care team attached to the group practice and be able to draw on the assistance of less highly qualified

staff when required, who may constitute a team of which she is the leader within the wider team;

- (f) whether a community nurse or midwife is working at the sister level in the field of clinical or of preventive health, we recognise, as we did in the case of ward sisters in hospital (see paragraphs 541–542 above) that exceptional expertise may be manifested, and that teaching, advisory or research functions may be added to those already exercised; in such cases, increased status and reward should be accorded in the way outlined in paragraph 542 above.

549. As part of the development of new management structures in the National Health Service, groups of family health and clinical sisters and their teams working in the community will be managed directly by Nursing Officers in their own specialty. In addition to their first line management responsibilities the Nursing Officers will often retain some case-work and provide guidance derived from experience for the nurses under their control, as well as for their colleagues elsewhere on a “consultancy” basis. Their functions, therefore, will not be purely administrative and should be compared with those of Nursing Officers in the hospital service.

550. We turn now to career opportunities for nurses and midwives at levels beyond the unit/field team, and, firstly, within line management. Appropriate management training should be available for all nurses and midwives at suitable points in their careers. The team management course, taken during pre-Registration training, would prepare the nurse and midwife to plan, evaluate and decide on priorities on her own initiative in allocating jobs to team members. Management courses at lower, middle and top levels should continue to be available to hospital and community nurses and midwives as preparation for advancement within the service, to the top posts if the range of their experience and their managerial skills justified it, whatever their original sphere of interest.

551. Many senior nurses and midwives will continue to work mainly from a hospital or a community base. Yet it is at senior levels, and particularly at top management level, that integration will have its most immediate effects, and it is there that many key decisions will be taken. Even those working primarily within one setting and continuing to fulfil the functions laid down for them under the Salmon and Mayston structures are bound to find themselves more closely involved with colleagues from other settings. We envisage that at middle management level there will continue to be Senior Nursing Officers in charge of, say, a medium sized hospital, part of a single large hospital or a group of small hospitals, and their duties will continue to include the long-term review of work patterns, allocation and redeployment of staff, cooperation with the Colleges in allocating students in accordance with teaching programmes and ensuring that adequate nursing and midwifery services are maintained at all times. Yet at some senior levels there will be officers concerned with both hospital personnel and manpower and community personnel and manpower. Likewise, in the community, while Area Nursing Officers will continue to manage groups of Nursing Officers, generally on a non-functional, geographical basis, in certain situations, for example in midwifery, some joint appointments spanning hospital and community services may be made.

552. We recognise that the bringing together under one single health authority of hospital and community nurses and midwives will result in a degree of inter-communication and of joint planning which has hitherto been inconceivable, and we welcome the opportunities it affords. Failures in communication have proved to be one of the major defects of the existing tripartite National Health Service, and although substantial strides have been made in recent years in bridging community nursing services and general practice through the extension, for example, of schemes of attachment, contact between the community and hospital health services remains poor in some areas and the standard of service to patients is suffering in consequence. As was pointed out in Chapter II, there is still a widespread lack of awareness among hospital medical and nursing staff of the range of community facilities and the quality and scope of functions of the existing home nursing and health visiting services. This "communication barrier" must be overcome in a reorganised service. Only then can constructive planning take place and policies be evolved for both hospital and community services which will overcome conventional budgetary and organisational barriers.

553. At this stage in discussion on National Health Service reorganisation, even acknowledging the generous cooperation we have received from those involved in its planning, it is impossible for us to make detailed recommendations about the top nursing and midwifery management structure. We have given very careful thought, however, to the principles which must be observed in any reorganisation of top management. In particular, we draw attention to the cardinal importance of the strategic posts now held by Chief Nursing Officers in hospitals and Directors of Nursing Services in the community, which require abilities of a very high order and offer scope for real participation by nurses and midwives in the evolution of health policies. Posts for nurses and midwives of comparable and probably of senior status must be part of the managerial framework of the integrated National Health Service. We regard the following features as important in any future structures:

- (a) existing structures should be interfered with as little as possible where they are working well;
- (b) line management should be further strengthened;
- (c) the proliferation of top management posts should be avoided;
- (d) there should be considerable flexibility of arrangements according to the size of Districts and Areas;
- (e) there must be proper liaison within the National Health Service and between it and local authorities;
- (f) a strong nursing and midwifery team should be established at Area level with executive functions;
- (g) hospital and community services will have to be integrated at both Area and District levels, although in the short term we recognise that two services may need to be administered in parallel below District level.

554. Within the organisation of line management, nurses and midwives from every field should be given opportunities to reach the top. At the top, chief nurses within line management will cover a wider span of responsibility than ever before and may need, at Area level at least, to call on the help in a staff capacity of specialist advisers in fields which are unfamiliar to them. Outside line management,

therefore, we see scope for a fuller development of staff posts at senior levels requiring special expertise of different kinds. All nurses and midwives should so far as possible have the opportunity of specialising in a particular subject if they desire, and in each case their work could span hospital and community care.

555. We have discussed in Chapter IV the make-up of the teaching team in nursing and midwifery, and the responsibilities of its members at different levels. The Colleges of Nursing and Midwifery, the establishment of which we recommend in that chapter, will stand in a different relationship to the service sector from the present educational establishments. Their range will be much wider, and they will be linked with larger combinations of hospital and community services. Given these differences, we think it would no longer be appropriate for the College Principal to come under the authority of top nursing and midwifery management, although close cooperation between the two will continue to be vital in view of their mutual interdependence. They should report through the governing body of the College to the Area Education Committee, and stand at the peak of a separate structure.

556. Finally, we emphasise, as we did in relation to ward and field staff, that opportunities for career development in management, in professional clinical specialisation or in teaching should not be mutually exclusive. Elements of each may be found in varying mixes in different posts and cooperation between practitioners of all three is essential. We hope that nurses and midwives will move freely in the course of their careers between all three fields. The detailed structures must be designed in such a way, therefore, as to allow for this desirable mobility.

NEW CAREER DEVELOPMENTS

557. The proposals outlined above apply, at least in the short run, to all branches of nursing and midwifery, and we have stressed that opportunities for advancement should be open equally to all nurses and midwives capable of undertaking senior posts. In the long run, however, we envisage fundamental changes taking place in the care of the mentally handicapped, with implications for staff employed in that field.

558. All mentally handicapped people may need services of three kinds to which nurses at present make a significant contribution:

- (a) therapeutic—for physical illness or disability or psychiatric disorder;
- (b) education, and occupational and social training;
- (c) “home” (or “parental”) care.

Doctors, teachers, occupational therapists and other specialists all contribute to meeting these needs, but staff are also essential with a wider responsibility for the patient’s personal care, and with understanding of and able to supplement the contribution of the specialist in the daily living situation. At present this wider responsibility for the three services outlined above generally falls to the nurse.

559. The extent to which individuals need these different elements of service varies widely. At present, for many of those in hospitals the predominant needs are those in the second and third categories, and it is generally accepted that when adequate community facilities are developed such people will no longer be ad-

mitted to hospital. Increasingly, therefore, hospitals will look after only those for whom therapeutic needs are predominant, although Cmnd. 4683¹ estimated that it may take some fifteen to twenty years before hospital patients are confined to those in this group. Yet even after this change hospital patients will not be limited to those whose physical or mental disabilities are so serious that their therapeutic needs alone need be considered, and social training, along with occupational and "home" care will remain an element in the service which hospitals for the mentally handicapped will have to provide for their patients. It will be essential even in the long run for hospitals receiving mentally handicapped patients to include within their establishments sufficient numbers of suitably trained and experienced staff to meet this provision.

560. The idea of creating a new professional group of "care staff" to undertake all but purely physical or mental nursing functions has been put to us in evidence from several bodies. Amongst the arguments used are:

- (a) that large numbers of mentally handicapped people in hospital have no significant physical or psychiatric disability requiring clinical nursing;
- (b) that too much emphasis in nursing care has been and is devoted to medical and "health" aspects and too little to the social development and needs of the mentally handicapped person as an individual or as a member of a group;
- (c) that it is illogical to regard the social and home-making aspects of care as "nursing" and to provide totally different training for those performing these duties in hospitals and in the community;
- (d) that this is also undesirable as likely to hinder the change in balance between hospital care and community care advocated in Cmnd. 4683¹;
- (e) that division of care into "nursing" and "social and domestic" elements, each to be provided by separate professions, would draw on a wider field of recruitment and thus help to relieve the staff shortages which currently present a major obstacle to improvement of the service.

561. Some people also point to evidence of "anti-therapeutic" features, such as regimentation, block treatment, depersonalisation and social distance in residential units managed by nurses as compared with those managed by child care staff. Others question the significance of this evidence and argue that it more truly reflects environmental differences and staffing standards than the relative abilities of different groups of staff. Contrary arguments have also been put, for example, that the introduction of an additional profession into hospitals would present serious difficulties through extending lines of communication and that nurses would see in the employment of "care staff" a diminution of their responsibility, a denigration of their past achievements and a threat to their career structure which would or could have a devastating effect both on morale and on recruitment.

562. Some of these arguments, on both sides, are very powerful; the significance of others may be exaggerated, but cannot entirely be discounted. From our own observation on visits and in taking evidence from individuals and bodies concerned with the care of the mentally handicapped, we believe that much of the

¹ See list of references, no. 32.

most successful nursing care being given at present in this field embraces the wider functions envisaged for "care staff", and that ultimately a new profession probably will, and should, emerge. We consider, however, that such a change should proceed by evolution and not by revolution as part of a broader group of changes.

563. We are reinforced in this view by the knowledge that major changes are at present taking place in the education and role of the social service professions, to which we believe "care staff" in the field of mental handicap, certainly those based in the community, would rightly belong. At a time when the environment for care of the mentally handicapped is changing, and when the social services are already under pressure, we think an attempt to introduce a totally new caring profession would be neither feasible nor desirable. Instead, we recommend more moderate changes in the short term, allowing for experimentation and development towards a realignment in care of the mentally handicapped between the health and social services.

564. First, we envisage a role for residential care staff of the kind now employed by local authorities working alongside nurses in mental handicap hospitals. In our view the appointment of staff with a suitable training in residential social work is to be encouraged. Such staff should be introduced gradually, if only because at present there are very few people with the right training. Gradual introduction would also minimise the problems of integrating them into the hospital staff structure.

565. Second, in the education of nurses working in the field of mental handicap emphasis should be placed on the social as well as the medical aspects of care, and there should be opportunities to develop this side of care at the Higher Certificate level. Our educational proposals, set out in Chapter IV, stressed the need for this change of emphasis. Nurses prepared in this way could ultimately have the opportunity to become the leaders of a new caring profession.

WORKING CONDITIONS

566. In Chapter V we discussed the setting up of manpower and personnel departments and their responsibility for policy formation at national, regional and Area level. Here we consider the operation of the personnel function not only by personnel departments at Area level but by nurse and midwife managers at all levels. The way the function is discharged has a very direct bearing both on career prospects and on working morale.

567. The caring professions generally, and nursing and midwifery in particular, are exceptional in that their conditions of work are organised and must be organised with a much greater than average consideration for the needs of the consumer/client. Nowhere is this more evident than in the widespread twenty-four hour nursing and midwifery coverage for the patient. To many nurses and midwives there are no high days and holidays, no weekends; there are just working days and days off. There is also a high living-in rate along with discipline which can be very strict. It is extremely important in such a situation that conditions generally are as good, well-thought-out and well-communicated as possible.

568. Senior nurses and midwives are already becoming much less resistant to change, more able to delegate, more critical of systems perpetuated by tradition and better at communicating the reasons behind seemingly unreasonable demands and involving their staff in reaching decisions together.

569. Any system which involves twenty-four hour coverage must obviously rely on large numbers of staff working shifts. Our opinion survey showed, as described in Chapter II, that two-thirds of hospital nurses and midwives worked some form of shift system. It also showed that most nurses and midwives were satisfied with their present shift arrangements, trainees less so than others. Based on these opinions there appears to be no immediate need for any drastic revision of shift systems generally. This is not to say, however, that there is no room for improvement, and we welcome moves towards rationalisation, such as day hospitals and five-day wards. We also recommend the provision, where possible, of a permanent night shift, about which we say more later in this chapter. We recognise that many factors impinge on shifts and hours and we deal with three of them in the succeeding paragraphs—transport, part-timers and the personnel function.

570. We make no detailed proposals on the subjects of shifts and hours; these we believe are best left to local arrangements. We would expect the personnel departments, on behalf of the Chief Nursing Officer, to have a general advisory and supervisory role to play. The actual organisation would need to be much nearer to the work situation, probably at the level of Nursing and Senior Nursing Officer, where detailed policies could be worked out to deal with problems such as those caused by emergencies and unexpected absences. We consider, nonetheless, that all systems, whatever the local differences, should take account of:

- (a) the efficient working of the hospital or community services and the provision of the best possible service for the patients;
- (b) the preferences and welfare of the nurses and midwives; and
- (c) the programme of education for students.

571. The shift system should be planned to achieve the best overall deployment of available nursing and midwifery manpower, both full-time and part-time, throughout the twenty-four hour span, and to provide adequate cover at the peak periods in the patient's day. We recognise the difficulties surrounding these peak periods, particularly the early morning 8 a.m. peak, when few part-time staff are available, and we welcome the appointment by the Standing Medical and Nursing Advisory Committees of the Central Health Services Council, of a sub-committee to review the pattern of the in-patient's day.

572. On the divisive subject of split shifts we note the following facts:

- (a) the NBPI Report No. 60¹ on the pay of nurses and midwives in the National Health Service (1968) recommended that split shifts should be discontinued;
- (b) the NBPI Report No. 161² on overtime and shiftwork (1970) showed that very few employees in British industry are employed on a split shift basis. The National Health Service is therefore unusual in this respect;

¹ See list of references, no. 83.

² See list of references, no. 82.

- (c) our own survey shows that thirty-two per cent of hospital nurses and midwives and fifty-eight per cent of student nurses work at least one split shift per week.

Although we realise that in some instances the split shift may meet the requirements of individual hospitals from both the work pattern and staff viewpoints, the straight shift has many advantages and is more attractive to the majority of staff. This is particularly true of the increasing number of non-resident staff and those working in hospitals situated away from residential areas and where transport facilities are limited.

573. Five specific features essential to a well run shift system are:

- (a) that it can be more effectively organised on a fortnightly or monthly pattern;
- (b) that it should provide for a regular pattern of two or three consecutive days off, with rotation at weekends, to enable the nurse or midwife to have a complete break from the hospital routine;
- (c) that the nurse or midwife should have adequate notice both of her allotted hours off duty and of any necessary changes in them;
- (d) that it should take account of the pattern of training which we have proposed; and
- (e) that it should include adequate provision for overlap between shifts for all grades of staff whilst attempting to obviate the problems caused by long overlaps in the middle of the day.

574. One feature of present organisation, the continuation of which we regard with apprehension, is the long twelve-hour day, which is still worked, particularly in the psychiatric field. We believe there is a danger that service to the patient may deteriorate after a nurse has been on duty for more than eight hours. One argument advanced in favour of long days is that their inclusion in the work rota makes it easier for the nurse to have two or three consecutive days off. By timing the duty rota on a two-, three- or four-weekly basis and by making full use of part-time staff it should be possible in most hospitals to arrange a rota excluding long day shifts. The continued use of long day shifts may be a deterrent to recruitment, particularly of female nurses. What is essential in all this, and we emphasise the point, is that the system should be flexible, should take full account of local circumstances, should be the subject of full preliminary discussions between staff at all levels and management and should be open to review.

575. We recognise that adequate night cover remains a severe problem in some hospitals. In general, however, the use of a permanent night shift in the hospital service appears to aid recruitment, since more day staff are available if they are not required to work occasional nights. Married women are frequently willing to work twilight shifts and night shifts on a part-time basis, the husband looking after the children. (Our survey of qualified nurses no longer working in the National Health Service showed, as we pointed out in Chapter II, that about half of those nurses who thought they would return at some time would work during the period 5.00 p.m. to 10.00 p.m., and a third would work during the period 10.00 p.m. to 9.00 a.m.) Double day shift working and permanent nights appear to suit a number of hospitals, because, as we said earlier, this arrangement

makes it easier to recruit day staff, and many do not find it too difficult to recruit a separate night shift. In specialist areas the nature of the work suggests that internal rotation may be preferable. More consideration should be given to the introduction of a permanent night shift, recognising that this will depend on the availability of a sufficient number of staff wishing to do night duty on a permanent basis. The organisation should ensure that links exist between night and day staff to ensure adequate up-dating, continuity of care and interchange of experience. Some hospitals have appointed Senior Nursing Officers to act as liaison officers between day and night staff to provide adequate communication. The span of night duty will normally be longer than day shifts and should include provision for adequate meal breaks outside the ward situation.

576. In the community nursing services not many local authorities operate a twenty-four hour nursing service. A night service and rota can only work where there are sufficient staff. Local authorities should assess their commitments at night to see whether there is a need for a night nursing service in their area. Where such a need is established and sufficient staff are available, one essential prerequisite for its efficient working is that the duty rota should be made available to the staff well in advance. Definition of the working week or fortnight in the community is also relevant, but this is a matter for the Nurses and Midwives Whitley Council.

577. On-call systems, under which nurses and midwives undertake night duty on a rota in addition to their normal daytime work, are the more frequent arrangement made, especially in rural areas, to provide cover throughout the twenty-four hours in the community service and are of particular importance in midwifery.

578. It seems clear from the evidence of experienced nursing and midwifery administrators and from that contained in our opinion survey that a well organised on-call system, in particular where group attachment schemes exist, is effective and is satisfactory both to patient and nurse or midwife. This is fortunate, for any attempt to introduce a shift system in rural areas would be very costly, and, moreover, would probably fail. There is an understandable disinclination on the part of some nurses and midwives to venture out unaccompanied at night into unfamiliar countryside. We conclude, therefore, that in such circumstances the on-call system should continue to operate. We recommend that:

- (a) as a first step a definition of the working week for community nurses and midwives should be agreed nationally and the extent of the periods during which nurses and midwives are on call should be limited. In parenthesis, the fact that a nurse or midwife is undertaking on-call duties will no doubt be taken into consideration when her case load is determined, and arrangements will be made for an appropriate reduction of her next day's work following a night of very heavy duty;
- (b) well-planned duty rotas should be given to nurses and midwives, and general medical practitioners informed well in advance;
- (c) the matter of appropriate remuneration for nurses and midwives who are on call should be considered nationally.

579. Where on-call arrangements are necessary in hospitals, we consider that similar action should be taken to that recommended for community services in sub-paragraphs (a) and (c) of paragraph 578 above. Integration will, of course, affect this issue; one possible arrangement for future consideration would be for night staff based in hospitals to undertake on-call duties.

COUNSELLING

580. Turning from general conditions of work to the individual nurse's or midwife's place in the system, we regard the creation of a comprehensive counselling service as an urgent top priority. At present no one person has responsibility for counselling. Many trainees are young, often away from home for the first time and may have domestic and other personal problems. They care for the ill, the dying and the disturbed. Yet it is not only trainees for whom a counselling system is necessary. Patients, relatives, and their colleagues make emotional demands on most nurses and midwives, and these can increase their own anxiety. We are satisfied that there is a definite need to offer emotional support. Many ward sisters, tutors and Nursing Officers provide such support, as do hospital chaplains, but there should be someone removed from the work situation to whom a nurse or midwife can turn for advice and support about her personal worries and about problems arising from work. Everyone (staff or students) should know of the arrangements, and procedures should be clearly and concisely set out.

581. The changing nature of medical care has added to the strain imposed on nursing and midwifery staff—anxiety about errors in medicine dosage, fears of machinery, the constant tension in intensive care units, the ethical problems of abortion, transplantation and resuscitation, uncertainty over rapid decisions to be made in times of crisis, the care of an increasing number of patients with mental disorders. This last aspect alone places a burden on general nurses for which at the moment they often have not been trained. The majority of attempted suicide cases are initially dealt with in general hospitals. Other aspects of nursing care making particular demands upon nursing staff are the treatment of drug addiction, care of the old and demented patients, care of the young chronic sick and terminal care.

582. Counselling is an important function, not just in relation to staff welfare, but in order to achieve an improved standard of patient care. Professor R. W. Revans in his important study¹, *The Hospital as an Organism: A Study in Communication and Morale* (1959), found evidence to suggest that hospitals able to retain their staff are also able to discharge their patients more rapidly, and directly connected recovery rates of patients with nursing and midwifery staff morale.

583. We visited a number of hospitals and local health authorities to discover how personnel matters were handled. Some hospital groups already have a Senior Nursing Officer holding a post in the personnel department, responsible to the personnel officer for the day-to-day handling of her work but accountable to the Chief Nursing Officer. This is the type of post we envisage in our recommendations in Chapter V. These Senior Nursing Officers will obviously have important responsibilities in the field of recruitment, but we envisage that they

¹ See list of references, no. 103.

could have a role to play in certain aspects of counselling. At one hospital we visited, the recruitment officer undertakes counselling. She considers her position to be suited to this as she is not part of the clinical administrative hierarchy, nor the school, and nurses and midwives therefore feel free from a clash of loyalties. This freedom we regard as valuable. Only one hospital we visited had a person in a post designated as "Counselling Officer", appointed specifically to undertake this role. She saw her job as getting to know the student nurses, making herself readily available, and acting as a centre where nurses could talk and be listened to, and from where their enquiries could be channelled to a more appropriate department. One student nurse suggested her job description might be "interested, available, no local axes to grind". We were impressed by this experiment.

584. We identify the main aspects of any successful counselling scheme as (a) academic advice and career guidance, to which we have already referred in Chapter IV and in paragraph 537 above, and (b) personal counselling. The first of these is particularly necessary for trainees (not least graduate trainees) who should have a personal adviser who should offer, and not merely be available for, educational advice and career guidance. There should also be a degree of flexibility in the allocation of trainees to teachers, to allow, if possible, for changes desired by either trainees or tutors. It is inevitable that trainees will ask for guidance from those with whom they find it easy to talk. We believe that senior nursing and midwifery staff in the clinical situation should be willing to listen to and offer advice and guidance to trainees, and should therefore be provided with suitable training in such matters.

585. Personal counselling should be available when needed. It is useful to try to create a network of different people and services covering help on a wide range of problems from education and career guidance to health matters. Many nursing and midwifery staff will encounter social welfare problems related to housing, transport, illness of relatives and so on. They should have access to the personnel department for advice on such matters, in addition to enquiries about conditions of work, methods of payment, pay increases, superannuation regulations and payment for various forms of special duties.

586. Where residential accommodation is offered to trainees, this should be controlled by resident managers or home wardens not accountable to senior nursing staff. There should also be a place for committees capable of influencing the management of residences or homes, and these should always include representatives of those in training.

587. Certain groups of staff will or may have special requirements in relation to counselling services—mature trainees, nurses and midwives who are retired, those with children and those born overseas.

588. We have already set out our views on the need to recruit more mature trainees in Chapter V and, given that this group will expand in numbers, it is essential that arrangements be made with a genuine will to meet their needs and to enable them to make their indispensable contribution to nursing. Some universities have appointed special counsellors for mature students, and we urge that the counselling network we have proposed should take account of this need.

589. Single nurses and midwives may retire at the age of fifty-five or sixty after many years of service. They may have no family, and there may have been little opportunity to save. Staff in this position are faced with very real practical difficulties as well as the need for emotional adjustment. Some private firms regard retirement as an indefinite period of leave and maintain contact with former employees, normally through a welfare officer. Some retired nurses and midwives might appreciate a similar interest in their welfare, particularly when they face housing problems. Many nurses and midwives live in tied accommodation and have to vacate their homes on retirement. Liaison with the housing department might avoid this.

590. The increased employment of married nurses and midwives with children is one of the changes we have noted in the labour force. Social trends, such as higher marriage rates, earlier marriages and increasing participation of women in the work force are all reflected in the nursing and midwifery profession. We have already discussed in Chapters IV and V some of the problems of part-timers. They include the need for part-time training, refresher courses, flexible hours for part-time staff, nursery facilities where appropriate and extended leave during the school holidays. Many of these nurses and midwives may have particular problems and require advice and support. Anxiety and insecurity are common in staff returning to work after several years and counselling should be an integral part of any induction programme.

591. In Chapter V we have illustrated the high incidence of overseas-born trainees and we have already pointed to the need for language and orientation courses in Chapter IV. The immigrant recruit will still need support and advice once training begins, and such advice should have special concern for those in an alien environment. Many hospitals recruit predominantly from one country so that the counsellor can develop a knowledge and understanding peculiar to its needs. Such counsellors should find out as much as possible about health and conditions in the countries of origin.

592. What is important overall is that there should be a body responsible for ensuring that counselling services exist, function and are used. For trainees this would be the governing body of the College. One of the criteria for the approval of a College by the Education Boards would be the availability of counselling services for trainees. For other staff it would be the responsibility of the Area Health Authorities/Boards through their personnel departments to ensure that both occupational health and counselling services were provided.

OCCUPATIONAL HEALTH

593. Although, as we have indicated, counselling goes far wider than health matters, they have a place in a comprehensive occupational service. In accordance with the proposals¹ of the Joint Committee on the Care of the Health of Hospital Staff, we recommend that all nursing and midwifery staff should have access to an occupational health service, possibly with a specialised element for trainees linked with other student health services where these are available. A sense of freedom is necessary in all such arrangements. Staff must be assured of the

¹ See list of references, no. 18.

confidentiality of any such service, should be able to register with a general practitioner of their choice, and should have the right to hospital treatment within or outside their own place of work. Through this occupational health service staff should also have access to a wide range of advisory services on health matters. They will also require a variety of professional services within the occupational health service to deal with problems of greater complexity in which worries may develop into nervous or mental illness. The professional staff involved here would include doctors, occupational health nurses and social workers. This team would itself require the assistance in a minority of cases of a consultant psychiatrist.

COMMUNICATIONS

594. Communications in any profession may be thought of as twofold—first, those within the profession itself and, second, those between that profession and others. We discussed the latter range of communications in relation to nursing and midwifery in Chapter II. Communications within the profession can be divided further into informal and formal communications. Good communications are an essential prerequisite of a good understanding between different grades of staff. Senior staff, as we showed in Chapter II, are sometimes not sympathetic to the particular needs of trainees, and it is apparent that they take a more optimistic view of the state of relationships between different grades of staff than do the trainees and auxiliaries. Similarly, junior staff are not always aware of the pressures to which senior staff have been subjected in recent years in adjusting to the radical changes in their work patterns resulting, among other things, from both the introduction of the Salmon and Mayston senior nursing staff structures and the many rapid changes in nursing and midwifery techniques. Emphasis should be placed on the need for good lines of communication both up and down. This is of particular importance in large acute hospitals, where the danger of breakdown in communications would appear to be the greatest because of greater pressures and extended lines of communication. We recommend that first line management courses should always include discussion on attitudes to staff and the need for good communications. We note, in this context, the comparative lack of research into the optimum effective workload that can be undertaken in a given ward or department, adding that the impact of undue pressures will inevitably be reflected in communications and the attitudes of nursing and midwifery staff to their colleagues and to their work.

595. In relation to formal communications, and to what we have said earlier about career guidance in paragraph 537, and counselling (paragraphs 580–592), we have noted that, like the Scottish Nursing Staffs Committee, the National Nursing Staff Committee have negotiated an appraisal scheme for trained nursing and midwifery staff. It has the following objectives:

- (a) to provide in a systematic way for performance review, to keep senior officers informed of this and of details of nurses and midwives thought to have the potential for advancement;
- (b) to provide a specific opportunity for counselling and for the nurse and midwife to discuss their progress and to help resolve any difficulties which impede good nursing and midwifery practice or management;
- (c) to identify any need for further training or broadening of experience;
- (d) to enable more reliable and informative references to be produced.

We agree that an appraisal scheme is desirable, but consider that its implementation must be carefully negotiated, and that there must be full consultation at local level.

596. Without wishing to infringe in any way on the work of the Davies Committee on complaints, we believe that it is important to stress at this point in our Report that procedures must exist and be used for dealing with complaints which affect staff, whether they arise between staff themselves, or come from an outside origin. Nurses and midwives who are aggrieved must have the opportunity of a fair hearing with appropriate help and support and the right of appeal to a higher authority where the outcome is unsatisfactory to any of the parties involved.

597. We turn now in some detail to the question of grievance procedures in relation to conditions of work. In the National Health Service, as in industry generally, the first objective of a grievance procedure should be to secure a settlement as quickly as possible and as near as possible to the point at which the issue arose. Normally this means an attempt to resolve it directly by discussion between the employee with a grievance and his or her immediate supervisor. The majority of individual issues are, in fact, settled in this way provided that (a) it is clear who the immediate supervisor is and (b) it is known that failure to achieve a solution at this stage will take both parties into a more formal stage at the next higher level. In National Health Service employment, (b) is often covered by nothing more than a general understanding that an employee with a grievance has a right of direct access to the most senior nursing or other officers. But junior employees are naturally reluctant to use this right unless a case has proved intractable at the employee-supervisor level, and a senior officer will often not become involved on either side until attitudes have hardened on what is felt, by then, to be a major issue of principle.

598. It is the middle stage of the grievance procedure which needs strengthening in situations comparable with those in private industry when the manager is able to take his case to the departmental head, who will normally seek the advice of the central personnel department, while the employee has the help of a friend or a professional association or trade union representative. In nursing, the relatively high concentration of Royal College of Nursing membership among senior nurses means that the member of the professional association whose help the nurse would normally seek may in fact be the supervisor or manager against whom she wishes to complain. Moreover, even if recognised departmental representatives of the professional associations and trade unions were identifiable, the low membership of nurses and midwives in professional associations and trade unions (a point we corroborated from our surveys, which showed that only one in two hospital and two in three local authority nurses and midwives belongs to a professional association or trade union) and high turnover among junior employees make it essential that the right to be represented by "a friend" should be included.

599. The main problem lies not on the side of employees and their organisations, but with management, whose performance in the personnel function at local level appears to us to be deficient in filling out the Whitley system as it affects individual grievances. There is a new duty on employers under the Industrial

Relations Act¹ to make clear in the contract of employment how an individual with a grievance should proceed. Though the formal requirements of the Act can probably be met without much difficulty, responsibility rests with the personnel staff at hospital level to ensure that a workable procedure exists for dealing with individual grievances.

600. One important feature in relation to grievance procedures is the lack of effective trade union machinery, at union steward level, in nursing and midwifery. There is almost universal reluctance on the part of nurses and midwives to take up this kind of role and yet courses for union stewards in other fields include instruction on grievance procedures. Industrial relations training is needed on both sides and the principle of representation of nurses and midwives by a nurse or midwife should be generally accepted. We recommend that personnel departments should be responsible for developing, as a matter of urgency, a grievance procedure which takes account of the special circumstances of nursing and midwifery work, and that some form of industrial relations training should be open to nurses and midwives.

601. Although there has recently been some revival of interest in Joint Consultative Committees (JCCs) at local (i.e., hospital or other establishment) level, the National Health Service experience with these kinds of institutions has not, in general, lived up to the expectations of those who made provision for them under the General Whitley Council more than twenty years ago. In part this reflects the experience of industry generally, where the existence of JCCs has often seemed to one or both sides to be an obstacle to a prior need for the development of procedures for negotiations, arbitration and the settlement of individual grievances. But there have also been some difficulties peculiar to the National Health Service. On the management side, the diffusion of responsibility for the wide range of topics which might be brought to a JCC has inhibited the development of management initiative in using the Committee, and there has also been a lack of understanding—in contrast with some other sectors of public employment—that this initiative from the management side is crucial in determining the success or failure of a joint consultative system. The items which are discussed at most hospital JCCs, where they continue to exist, are usually of the kind which appeared on staff welfare committees which were set up elsewhere during the 1920s and 1930s, and only very rarely are management goals and strategies put to a representative committee of employees in such a way that they can be re-examined and modified in the light of employees' comments. On the staff side, a major obstacle to progress has been the non-participation of medical staff, and nursing and midwifery staff have often followed this lead and assumed that joint consultation would correspondingly be of little value to nursing and midwifery interests.

602. We do not have a sufficiently wide remit to make recommendations about joint consultation as such, because all grades of staff are potentially within the scope of local JCCs. We note, however, that the present time is an appropriate one for a reconsideration of joint consultation at local level. The Industrial Relations Code of Practice² recommends that any establishment with more than 250 employees should have a consultative committee with an elected

¹ See list of references, no. 55.

² See list of references, no. 24.

membership representing all sections of the establishment, and sectional sub-committees where appropriate. Management should take the initiative in setting it up in consultation, as appropriate, with employee representatives and trade unions.

603. In the near future the new management structures under integration should provide a new basis for management initiative (and also a new basis for the choice of representatives in the case of some occupations), although it is far from clear yet how quickly the system will move on from a hierarchy of line management with supporting staff and advisory committees towards a network of multidisciplinary teams which are constituted on an *ad hoc* basis. With a shift towards the latter, a representative joint committee at establishment level would evidently take on a new significance as part of a participative management structure, dealing with matters affecting the operation of the establishment as a whole.

604. Nurses and midwives have perhaps most to gain from such a reconstitution of joint committees, because their comprehensive responsibility for the care of the patient needs to be supported in all possible ways by participation in the overall management of the establishment. It is not difficult to see how sub-committees could be set up to cover particular functional areas, and in one representative system which we examined, for example, there are three sub-committees covering hotel and in-patient services (including ward nurses and junior medical staff), out-patient and medical services and group services, with the permanent medical staff forming a fourth "constituency". We welcome such experiments in the context of an evolving management structure, but also note that they take conventional JCCs towards management and away from their quasi-negotiating function, which could lead to difficulties if industrial relations matters are not dealt with adequately by other means. Most of these are in fact covered at a higher level than that of the establishment.

THE WORKING ENVIRONMENT

605. There are many items under this heading, and we confine our discussion to those which strike us as being the most important. We understand that all hospital authorities possess the discretion to approve assisted travel schemes in circumstances where either the hospital is isolated or badly served by public transport or where, because labour is in short supply in the area of the hospital, staff have to be attracted from a distance. These arrangements, which cover staff within a salary maximum, may take the form of either the provision of hospital transport and deduction of specified minimum charges or partial reimbursement of fares on public transport. Staff outside the scheme, because of grade, may use hospital transport, but are required to pay the equivalent of the transport fare. We see an urgent need for expansion of this provision to meet the needs of all grades, particularly in those areas where public transport arrangements do not fit working hours. In certain circumstances, where hospital transport is not provided, Boards may approve arrangements for assistance if staff travel to work by private car. These arrangements appear to be generally adequate provided Boards and Hospital Management Committees make the maximum use of them. It is also important that car parking facilities for nursing and midwifery staff at hospitals should be extended wherever possible.

606. In Central London, travel arrangements create a special problem, particularly with regard to the possibility of recruiting married women returning to the profession after a break to bring up their children. Here the problem is not so much the provision of transport facilities as the expense of travel into the centre for those living on the periphery in view of the competition from nurses' agencies, many of which repay fares. Increased use of arrangements for partial reimbursement of fares in Central London hospitals might help to counteract their increasing reliance on agency nurses and midwives.

607. There are no centrally approved arrangements for community nurses and midwives similar to those for hospital nurses and midwives. However, transport facilities for staff will be of no less importance in the developing community services, and it is essential to ensure that employing authorities make adequate provision to enable them to attract staff. The car is an essential tool for many nurses and midwives working in the community, and employing authorities can help by (a) making available loan facilities to those nurses and midwives who wish to purchase their own cars, and (b) providing a pool of cars for those staff who do not wish to purchase their own. Our survey showed that a quarter of district nurses and domiciliary midwives had the use of a car provided by the local authority, but only eleven per cent of health visitors did so. The majority of community nurses and midwives, however, used their own private car; in all eighty-five per cent used a car and only three per cent used a bicycle, moped or scooter; twelve per cent were reliant on public transport or their own feet but only three per cent of district nurses and two per cent of domiciliary midwives had no form of transport of their own. About a third of those using their own car had received help in its purchase in the form of a loan from the local authority. This latter fact particularly points to a large amount of disparity between geographical areas, some of which is no doubt due to variations in local requirements and transport systems.

608. We consider that not enough attention is paid, at what will in future be District level and below, to the need to bring to the attention of nurses and midwives, through such channels as hospital news letters, the facilities available for study leave and payment of expenses for those wishing to attend post-Registration study courses and conferences. We feel that the assistance now available for nurses and midwives who wish to be seconded for a year of whole-time study to complete a first degree course should be extended to cover Master's degree or post-graduate courses, which are of particular relevance to nurse tutors, midwife teachers or, in future, lecturers.

609. We understand that the Social Science Research Unit of the Department of Health and Social Security is at present making a study of accommodation for nursing staff. There are enormous variations in the standards of residential accommodation provided for nursing and midwifery staff. An attempt should be made to provide a better general standard of accommodation. This could be an aid to recruitment, as could also an increase in the freedom for nurses and midwives to choose whether they should be resident or non-resident. The designation by hospital authorities of an officer responsible for staff accommodation, who would be in touch with new generations of nurses, could help both in the allocation of hospital accommodation to those nurses and midwives who wish to be resident and in the dissemination to non-resident staff of information about

suitable accommodation outside the hospital precinct. It is also important to ensure that the type of accommodation provided by hospitals is within the financial range of the staff for whom it is provided.

610. Supervision of nurses' and midwives' residences should be kept to a minimum and we do not consider that there is any need for a home warden for qualified nursing and midwifery staff. Once the nurse or midwife has been allocated accommodation it should be regarded as his or her home, and other hospital staff should have access only to clean it or, in the case of the responsible officer, periodically to ensure that this cleaning has been properly carried out.

611. We note that a scheme has been introduced from 1 November 1971 to enable hospital authorities to give financial assistance to officers who take up new posts necessitating removal of their homes and who have difficulty owing to lack of capital in arranging house purchase in the area of their new headquarters. The scheme, details of which are in HM (71) 89¹, provides for an advance, not exceeding three months' gross salary or £400, whichever is the greater, recoverable from salary over a period of not more than ten years.

612. In the community field, it is particularly important that a district nurse or midwife should live close to the locality in which she works. At present many local authorities are able to help in providing accommodation to meet this need. However, there may be particular problems after 1974 when community nurses and midwives cease to be employed by the local authority.

613. As a rider to our discussion on living conditions in the preceding four paragraphs, we consider that in view of the increasing number of non-resident staff it is essential that there should be adequate provision of changing rooms and rest rooms.

614. Finally, in view of the increasing numbers of women with young children working as nurses or midwives, we point out the need for health authorities to consider the provision of day nurseries as an aid to recruitment and retention. Day nurseries can be expensive, and clearly costs should be equated at local level with the return on investment by way of additional recruitment, but where circumstances are favourable, they can make a useful contribution. Employment of many more married women with school-age children also presents a great staffing problem during the long school holidays and we would welcome the alleviation of this problem by the provision of holiday play centres for this older age group of children.

615. There is little which we are recommending in this chapter which is not already being accomplished in the best instances. Unfortunately, standards vary remarkably, as does the quality of the imaginative response to the challenges of a changing profession. Some of the biggest and most exciting career opportunities in nursing and midwifery relate to caring for the profession itself and ensuring that it can carry out the necessary changes to meet the needs of an integrated National Health Service.

¹ See list of references, no. 36.

CHAPTER VII

ORGANISATIONAL FRAMEWORKS AND TIMETABLES OF CHANGE

THE SCOPE OF THIS CHAPTER

616. In seeking to programme nursing and midwifery resources to meet patient needs, it must be recognised that nurses and midwives themselves, as was emphasised in Chapters I and V, must play the major part in identifying those needs and in making sure that they are adequately met. At the same time, the Health Departments must concern themselves, as must the Regional and Area Health Authorities/Boards, with the recruitment and deployment of manpower, and nurses and midwives must work closely with other members of health teams at every level.

617. In this chapter we are concerned with machinery and timetables, beginning with education. We concern ourselves also with resources. The changes we suggest must be carefully costed in relation to other demands on the National Health Service. Some of our proposals about machinery must be in general terms since a number of crucial questions concerning the detailed structure of an integrated National Health Service have not yet been answered. At the same time we point, first, to what seem to us to be the essential elements in a new statutory structure for nursing and midwifery and, second, to the order in which future developments should in our view take place.

SPEAKING WITH ONE VOICE

618. At present there is a wide range of bodies concerned with nursing and midwifery education and directly or indirectly, therefore, with the future of the profession. Some are statutory bodies¹; others have wide experience and carry out teaching and/or research activities². We have been impressed by the quality of the evidence each one of them has presented to us and with the care and sense of public responsibility with which the evidence was compiled, in some cases after a comprehensive review. It is in no sense because we fail to recognise the achievements of these bodies that we recommend that in the interests of the profession there should be one single central statutory organisation to supervise training and education and to safeguard and, when possible, to raise professional standards.

619. We believe that the existence of such a single organisation would guarantee

¹ Central Midwives Board, Central Midwives Board for Scotland, Council for the Education and Training of Health Visitors, General Nursing Council for England and Wales, General Nursing Council for Scotland.

² Some of the main bodies are: British Thoracic and Tuberculosis Association, Joint Board of Clinical Nursing Studies, Joint Examination Board, British Orthopaedic Association and Central Council for the Disabled, Midwife Teachers Training College, National Nursing Staff Committee, Ophthalmic Nursing Board, Panel of Assessors for District Nurse Training, Queen's Institute of District Nursing, Royal College of Midwives, Royal College of Nursing and National Council of Nurses of the United Kingdom, Royal College of Psychiatrists and, where relevant, parallel Scottish bodies.

that an authoritative voice for British nursing and midwifery would be heard outside the profession within this country and in the long term, of equal importance, within the EEC, particularly given that the pattern of attitudes and policies within the EEC is still evolving. We believe that within the national and the wider international context that voice is an important one.

620. We recognise, however, the existence of separate responsible Government Departments in England, Scotland and Wales and separate legal and educational conditions and systems north and south of the Border. We recognise also the intention, as expressed in the various Nurses and Midwives Acts¹, that the training of nurses and midwives north and south of the Border should be of a uniform standard. Inevitably separate Councils and Boards produce different training requirements. There is increasing evidence of this with the different minimum ages of entry to nurse training, different attitudes to training for the register and the roll and different standards of entry to midwifery training, and while we have no desire to impose standardised patterns, we do not think that this particular divergence can benefit either patients or the profession.

621. In coming to our decision, we have given equally long and careful consideration to the needs of the branches of nursing well served at present by separate bodies, and to the needs of midwives. We recognise that in some respects those needs diverge. But we believe that what the branches of a united profession have to give to each other is more significant and more fundamental than the respects in which they differ. We believe that a structure can be created in which essential differences are safeguarded within the overall unity and anomalies—for instance in relation to the financing of education—can be removed.

622. We do not think that consultation between separate Councils and Boards, which we are told has increased in recent years, is a good substitute for common participation. In all parts of Great Britain the same trends towards integration of the National Health Service (community and hospital) are apparent and policies in the long run converge. Indeed, our conception of a unified and continuous educational process, carefully thought out and planned, with the different parts relating to each other, leads us naturally to propose an administrative structure which avoids both fragmentation and overlapping. It also secures for those concerned with post-basic specialisation, whether as nurses or as midwives, the influence they should wield over the formative period during which the foundation for that specialisation is laid. We wish to see education in nursing and midwifery become more systematic and be given a far greater degree of independence from the service sector, while retaining a realistic relationship with service needs. The objective can only be realised if the central organisation has real powers and can speak for the profession as a whole.

623. We recommend the creation, therefore, of a Central Nursing and Midwifery Council for Great Britain which will be able to draw on the knowledge and experience accumulated by responsible statutory bodies in the past.

624. We recognise, of course, that there are significant local and regional differences within Great Britain. While local conditions within each of the three

¹ See list of references, nos. 71, 72, 73, 90, 91, 92, 93, 94, 95 & 117.

nations in Great Britain vary considerably, as we showed in Chapter V, the national differences seem to us to be of special significance in that they affect both the education and the practice of the profession.

625. We wish to ensure that in future there is a proper balance between the central, the national and the local. Recognising national characteristics and separation, therefore, we recommend that there should be three distinct Nursing and Midwifery Education Boards for England, Scotland and Wales, each reporting direct to the Central Nursing and Midwifery Council. These bodies will cover the whole field of nursing and midwifery education, except, for reasons set out in Chapter IV, management education and developments associated with it.

MIDWIFERY

626. We have considered carefully how the interests of midwives and their patients can best be served within the structure we recommend, and have noted the evidence, presented to us with feeling, that there should continue to be organisational separation. We are convinced, however, that while the special features and the distinctive problems of midwifery must be considered specifically both in their national and in their European context, the future of midwifery is so intimately bound up with the future of nursing as a whole that this is the time to begin to fuse separate structures. We note that most midwives are already nurses, and we recommend that in future all midwives should be nurses. We note that the work of midwives contains a recognisable nursing component as well as a component unique to midwifery. We believe that midwives and nurses have much to contribute to each other's education and experience and that both will gain from shared policy making within a body in which their professions are in a majority. Discussions between nurses and midwives about education and professional standards should be easier in bodies where both are represented than in negotiations between separate statutory authorities.

627. At the same time, we recognise the existence of real and important differences between nursing and midwifery. After careful consideration, we conclude that there are aspects of midwifery practice on which a body dealing also with all aspects of nursing could not rightly pronounce with the necessary degree of authority. We recommend, therefore, the setting up by statute of a Standing Midwifery Committee of the Central Nursing and Midwifery Council, which should include expert midwife and other members in addition to those belonging to the main Council. We recommend that a majority of the members of this statutory Committee should be midwives. Finally, we recommend that midwifery should be represented in proper strength both on the Central Nursing and Midwifery Council and on the three national Education Boards.

628. Midwives have in their practice had an unusual degree of clinical responsibility and independence, greater traditionally than that possessed by nurses. This responsibility has been excellently discharged and we wish to maintain these high standards of practice. Our recommendation that there should be a Standing Committee on Midwifery should, however, not be understood as meaning that the clinical responsibility of the nurse is now or should in future be less than that of the midwife.

629. The Standing Committee on Midwifery would exercise a dual function. First, it would consider all matters relating to midwifery education, and advise the Council and the Boards accordingly. Second, it would act as the national statutory body concerned with the control of practice in midwifery, including responsibility for the employment of new drugs and procedures by midwives. We envisage this function of control being extended in the future as a result of organisational change within the National Health Service. From 1974, local authorities will lose their functions as local health authorities to Area Health Authorities/Boards. Historically, they have been responsible for the local supervision of midwifery practice. They will in future lack the expertise for this task; on the other hand, there could be a conflict of interests if it fell to the employing authority. In evidence to us, the Central Midwives Board (for England and Wales) expressed the view that the function of local supervision should in the future be exercised by itself, possibly through a system of annual licensing to practise. We think that this proposal is worth following up, and that the function might well fall to the Standing Committee we propose; and we recommend that study be given to ways of securing an effective continuation of local supervision through that medium.

THE COUNCIL AND THE BOARDS

630. We see the relationship between the Central Nursing and Midwifery Council and its three Education Boards as follows. The Council would be responsible for:

- (a) the maintenance and development of professional standards and the control of professional discipline;
- (b) the determination of the broad principles of educational policy;
- (c) Certification, Registration, and the maintenance of relevant records;
- (d) negotiations with counterparts of the Council in other countries about such matters as reciprocity of qualifications;
- (e) monitoring and coordinating the activities of the Boards.

631. The three Education Boards would each be responsible for:

- (a) the administration of nursing and midwifery education;
- (b) the allocation of finance, subject to scrutiny by the Council, for nursing and midwifery education including the payment of training allowances;
- (c) the vetting and approving of educational institutions and programmes and assessing whether or not they satisfy the principles laid down by the Central Nursing and Midwifery Council;
- (d) the maintenance and improvement of educational standards through regulations relating to reductions in course length in respect of previous education and experience, teacher/student ratios, curricula, syllabus outlines, assessment and examinations and the award of non-statutory qualifications;
- (e) the inspection of Colleges of Nursing and Midwifery and their training centres and activities;
- (f) the promotion of research.

632. In short, the Council would lay down the broad principles of nursing and midwifery education, and the Education Boards would have full responsibility for

the detailed organisation and implementation of that policy. They would report annually to the Council on their work and submit their budgets to the Council for scrutiny. The Council would survey the whole field and, if necessary, initiate discussion about aspects of policy in the Boards.

633. We believe that the leadership function of the Council will be of crucial importance. It must not be a figurehead committee but rather a real and active force in reshaping the profession within an integrated National Health Service. The ideal of a united profession within Great Britain, seeking the same goals in an imaginative and coordinated fashion, should always be kept in view.

634. We do not wish to specify in detail what the size and composition of each of the bodies mentioned above should be. This should be a matter for negotiation. Yet we wish to draw attention to some of the underlying principles. We recognise that whereas, if all nursing and midwifery interests were to be represented on the Council, it might become unwieldy, if it were a small body it might not be possible to have adequate representation of educational experience in the nurse and midwife teaching profession and in other related fields of education. We ourselves attach more importance to the quality of its leadership than to the mathematics of representation.

635. In our view equity in representation should be achieved through arrangements which ensure fair representation in *both* Council and Boards taken together.

636. Whatever the detailed composition, four principles seem to us fundamental:

- (a) there should be the closest consultation between those responsible for the nursing and midwifery service and those responsible for nursing and midwifery education;
- (b) as nursing and midwifery education and service are interdependent and interrelated, educational needs should not be treated as subservient to the needs of the nursing and midwifery service;
- (c) nursing and midwifery education should not become isolated from the mainstream of general education;
- (d) attention should be paid throughout to research needs as well as to teaching.

637. While recognising that final details of membership cannot and should not be settled without full consultation, we urge that discussion and negotiation should take place as expeditiously as possible, since the agenda of the new authorities includes items of great urgency. No avoidable delay in the setting up of the new authorities should be tolerated. In the hope that it will be of assistance in reaching final decisions, we set out certain criteria which in our view should be quickly accepted:

- (a) nurses and midwives should be in the majority on both Council and Boards;
- (b) members should be drawn from a wide spread of geographical areas;

- (c) members should represent the various aspects of nursing and midwifery at different levels, and should include nurse and midwife educators as well as nurses and midwives involved in the service;
- (d) non-nurse members should include among others doctors, people with knowledge in the field of general education, health service administrators and financial experts;
- (e) there should be an element of cross-membership between Council and Boards.

638. We have considered long and carefully whether there should be an elected element in the Council and Boards, and if so at what level. We are aware that, while there is election at present to some of the statutory bodies, others have an entirely appointed membership. The advantages of having an elected element seem to us to lie in the involvement of nurses and midwives at all levels in the government of their own profession; on the other hand such involvement may be more apparent than real when candidates are unknown to the majority of voters. Questions of balance may also be harder to resolve in a body which is partly elected.

639. Weighing the arguments, we recommend that there should continue to be an elected element in the Council. We think it right that a profession should have a say in the membership of the body which sets its standards and maintains its discipline. We believe that problems of balance can be overcome by stratifying the electoral system to secure representation of necessary elements, geographical and functional, and by associating an elected element with an appointed element, thereby allowing a certain degree of flexibility. We make no recommendation on the question of election to the Boards.

AREA ORGANISATION

640. Since any arrangements for the organisation of nursing and midwifery education at Area and District level will be influenced by proposals for the reorganisation of the National Health Service at present being considered by separate working parties set up by the Secretaries of State, we wish to emphasise general points relating to local machinery rather than to present a definite and comprehensive plan. We would stress, however, that it is essential that in their final form they should be deliberately designed to assist reorganisation and promote integration.

641. In our view there are four main reasons for identifying an administrative level below that of the three national Education Boards:

- (a) it would be difficult administratively for Education Boards, especially in England, to deal directly with all the Colleges of Nursing and Midwifery which we projected in Chapter IV;
- (b) it would be difficult to assess financial priorities if annual grants had to be made direct from a central authority to individual Colleges;
- (c) Colleges cannot operate in isolation. They will be part of a wider network and will be concerned with the secondment of students for clinical experience, the use of educational and social facilities in other institutions, planning of pre-nursing courses, courses for teaching and so on;

- (d) local attitudes and priorities should be stated clearly at a level where they may effectively be taken into account.

642. We have considered (a) whether there should be one or two levels below the national Education Boards and (b) whether if there were to be one level it should be regional or Area. We conclude that we do not see any need for two levels. An over-elaborate administrative procedure would be introduced if national Education Boards were to lay down policy for and to distribute finance directly to regional councils, if regional councils were to go on to play the same part in relation to Areas, and if Areas were to play the same part in relation to Colleges. In our view, only one agency is necessary below the level of the Boards. This view is reinforced by our desire to allow the maximum responsibility and scope for displaying initiative to Principals of Colleges of Nursing and Midwifery.

643. For a number of reasons, we conclude that the one agency should not be at regional level. There is to be no regional tier in Scotland or Wales, so that a regional authority would be inappropriate outside England. Furthermore, the number of Colleges falling within each Region would make for difficulties in securing adequate representation of local attitudes and sufficiently intimate knowledge of local problems and opportunities. Finally, a regional structure would not help in forming the natural links which we are anxious to see established between those responsible for vocational education and those responsible for further and higher education generally.

644. The setting up of one agency for each Area would, we believe, have different disadvantages. While some Areas are likely to be large enough to support a viable agency, a substantial number may contain only one or two Colleges. To superimpose a further administrative structure above a single College or two Colleges only would confuse the functions of Education Committees and governing bodies of Colleges and would nullify or impair the objectives of coordination and determination of priorities. We therefore suggest:

- (a) that there should be Area Committees for Nursing and Midwifery Education, with boundaries coterminous with and including one or more Area Health Authorities/Boards;
- (b) that no Area Education Committee should normally have responsibility for less than four or more than eight Colleges.

645. We have already expressed the view that education and service are interdependent and that both should be represented on policy making boards and committees. At Area Education Committee level it is essential that there should be agreement with the service authorities on such questions as the amount of experience that can be made available to students and how best this can be utilised. Only full cooperation between those responsible for education and service can achieve agreements which will reconcile educational requirements and the interests of patients. The Area Education Committees will also need to consider the availability of pools of recruitment and of future job opportunities in determining the location of courses and numbers and criteria for recruitment. Here again, both educational and service interests must be involved.

646. We do not consider that we can make detailed recommendations about the composition and precise functions of the Area Education Committees at this time, if only for the reason that the powers and organisation of the Area Health Authority/Board have not been settled. Yet, whatever the details of Area administration, the Area Committees for Nursing and Midwifery Education should include:

- (a) representatives both of nursing and midwifery education and of other branches of education including higher education;
- (b) members appointed by the Nursing and Midwifery Education Boards;
- (c) senior officers of the Area nursing and midwifery service;
- (d) representatives of nurses and midwives at ward and field level;
- (e) members appointed by the appropriate Secretary of State (including members of Area Health Authorities/Boards);
- (f) members appointed by local education authorities.

647. The composition of the Committees should ensure:

- (a) that there should be mutual understanding and the closest cooperation between those responsible for the nursing and midwifery service and those responsible for nursing and midwifery education;
- (b) that there should be an opportunity for discussing patterns of nursing and midwifery education in the light of change in the organisation and scope of the national educational system as a whole.

648. In considering the relationship between Area Education Committees and the national Education Boards we have reached the following conclusions:

- (a) there should be the maximum delegation of authority from national to Area and from Area to College level. We believe that it is essential to liberate energies, to foster initiatives and to generate experiment. The vitality of the new educational system will depend in the first instance on the calibre of the Principals of the Colleges of Nursing and Midwifery; in our own approach to education we start, as we did in discussing the role of the nursing and midwifery team, "from below";
- (b) there should, nonetheless, be a determination to act nationally through national campaigns and, when necessary, through national provision of funds to secure urgent objectives, for example, the mobilisation of mature entrants to the profession.

THE ROLE OF THE DEPARTMENTS

649. A number of bodies recommended to us that responsibilities and powers for nurse and midwife education should be transferred from the Health Departments to the Education Departments. As we have stated earlier, we do not favour such a transfer, although we would welcome continued consultation between these Departments. We believe that it is only within the Health Departments, which are concerned with manpower forecasting and manpower deployment, that educational policies can properly be related to long-term manpower needs, and we consider it essential that Departmental projections prepared in the manpower and personnel units should be discussed regularly with the Central Council to ensure a common approach.

650. The Health Departments must also exercise a coordinating function in relation to health and social service policy. Indeed, this coordinating function is a precondition of local coordination. Given what we have said about the significance of the relationships between nurses and midwives and social workers, and the importance of considering questions of nursing and midwifery needs in their social setting, there must be formal as well as informal links at top and bottom between policy makers and administrators in the health and social services.

CONSTRAINTS AND RESOURCES

651. We have taken into account in making the proposals set out above that they cannot all be implemented at once and that a realistic timetable of change is indispensable. Realism will not be enough, however: there must be the will to change and a sense of urgency.

652. Some of the factors affecting the timing of change are outside our control. We have drawn up our plans on the basis of an integrated National Health Service and, although planning and preliminary work can and should begin earlier, the final fruition of some of our plans must wait until integration is much further advanced. We have also taken into account in our planning trends which are emerging gradually. As we noted in Chapter I, changes in the balance between hospital and community care, the move towards the district general hospital, increased emphasis on selective dependency care, day wards and five-day wards, general practitioner units, attachment of local authority nurses to general practitioners, the integration of the maternity service, increased early discharge, more hospital confinements, new attitudes to the care of the mentally ill and handicapped and many other developments are already evolving and will continue to do so for years to come.

WHY MORE SPENDING?

653. Putting all our proposals together, we are suggesting substantial extra expenditure on nursing and midwifery education. What is the justification? It can hardly be found (as it often is) in general arguments that it is so obviously a "good thing" to spend more on nursing and midwifery education that no more rational justification is needed. Nor is the fact that levels of spending on education in nursing and midwifery have been very low in the past a full justification in itself for spending more.

654. Ideally, we would want to be able to weigh increased costs against detailed assessments of the benefits in terms of patient care and of quicker recovery. But there are two difficulties involved in this, as we have pointed out in Chapters I and V. First, no satisfactory measures have yet been devised of the "outputs" of the National Health Service. Quantitative measures of case load tell us nothing about the quality of care received. Second, it is difficult to separate out the specific contributions of various "inputs" and grades of staff to patient care, and even more difficult to weigh the contribution to patient care of a change in expenditure on the training of one type of staff. Arguably—and there is some statistical evidence for this—increases in medical time available are the most important means of accelerating treatment and recovery. But there is evidence of a different kind

that a reasonable standard of nursing and midwifery care is essential to recovery. Obviously bad nursing and midwifery care and staff shortages can threaten lives while good nursing and midwifery care can save them.

655. Although we cannot make precise statements about the benefits to be expected from the increased costs, we are clear about the importance to patients both in the long run and in the short run of nursing and midwifery standards. We have no doubts that the extra expenditure suggested in our Report is needed if these standards are to be maintained and improved.

656. At the same time, the additional spending we recommend on education in nursing and midwifery makes sense for the service only if the other changes suggested in our Report are implemented. The pattern of skills has to be fitted much more closely to the needs of the work. There has to be much more concern in the service for the wise distribution of nurses and midwives between hospitals and in relation to different types of care. The moves towards integration require a rethinking of policies. Finally, we call for new efforts to use nursing and midwifery time effectively at ward and field level and for increased research into effective care.

657. Throughout we wish to see a new emphasis on the quality of care. Raising numbers in isolation from policies to improve standards in care and the distribution of nursing and midwifery staff is not a solution to the problems of nursing and midwifery. The new education programme aims not at a general increase in the technical sophistication of education but at the training of a wide range of nurses and midwives, each of whom at all levels will be more confident in the exercise of his or her skills. A whole series of changes is needed both to ensure that the new training is successfully introduced and that its benefits will be widely felt.

658. Thus, the most important part of the case for increased spending is that a more appropriately trained profession could make a substantially greater contribution to patient care as long as their time and skill are put to more effective use. But there is also an economic case for the changes we propose. We have already drawn attention to policies which envisage a shift in the focus of care from the hospital to the community and, in particular, radically new approaches to the care of the mentally ill and handicapped. The demands on nurses and midwives have changed and are changing; the existing education system, with its emphasis on specialisation from the beginning, calls for long periods of retraining before a nurse or midwife can move into a new sphere. Our proposed system allows for considerable flexibility of function and rapid additional training to meet new situations as they arise. While the initial investment in education to the level of Registration is increased, there is a correspondingly good economic return in the form of a work force which can be adapted to changing demands faster and at less cost to the individual and to the service than at present.

659. We believe that this return will increase in value as change continues and accelerates. It is of particular importance given the expectation that many nurses and midwives will leave the profession for a time to rear their families and return to what may well be a considerably altered task.

660. The flexibility to which we refer has a second aspect; it relates not only to specialisation but the "depth" of skills. The Certificated nurse will qualify to practise at basic level in less time than the present enrolled nurse; she can also become Registered in a shorter period than the enrolled nurse can achieve registration at present. Whether she chooses to practise at basic level, therefore, or decides, at whatever stage, to proceed to Registration, her education represents a net economic gain to the service. It is our belief that it will also represent a gain in quality of service.

MANPOWER PROBLEMS OF THE PROPOSALS

661. Our proposals clearly make demands on manpower. They pose several questions. First, can staff be recruited to make up for the reduced work contribution of trainees? This is a particularly important question for the non-psychiatric hospitals and for midwifery. Hospitals for the mentally ill or handicapped and geriatric hospitals will gain in nursing resources as a result of a more comprehensive system of nurse education, and in the community the main problem will be that of increased supervision rather than of reduced work contribution.

662. If the new education programme we are recommending is implemented, about 14,500 extra staff will be needed in the non-psychiatric hospitals in Great Britain in seven years' time to replace the work contribution of students on secondment or undergoing theoretical education if workloads remain at their current levels. We have examined the feasibility of recruiting these extra staff in three main ways: against past rates of growth of staff and current recruitment prospects, against expected future rates of growth, and by looking at the meaning of the change for specific hospitals. If the replacement were effected by one-third qualified staff and two-thirds aides, the extra requirement will be 4,800 extra qualified staff and 9,700 aides. Can these be recruited in Great Britain over a seven-year period?

663. For Great Britain over the seven years from 1963 to 1970 the numbers of qualified staff in non-psychiatric hospitals rose (in terms of whole-time equivalents) by 24,988. We recognise that the demand for extra staff during this earlier period came from various sources and that with a continuing rise in total workload not all the future growth of staff can be pre-empted for the training programme without serious strains becoming evident elsewhere in the service. Yet we regard the past record as a useful indication of whether the supply is there to be recruited. On the evidence we believe it is.

664. Past numbers alone may suggest that the recruitment of aides will be a more difficult problem. The numbers of unqualified staff in terms of whole-time equivalents rose in the non-psychiatric hospitals by 17,791 in Great Britain from 1963 to 1970, a smaller numerical change, even though it registered a very large annual growth rate. Our local studies suggest, nonetheless, that the prospects of recruiting more aides are good. We came across hospitals in areas where the demand for labour was high in which recruitment drives had met stated needs. We also came across hospitals—often in areas offering fewer opportunities to women to work—which had waiting lists for jobs. The evidence on the women's labour market suggests that, both in terms of pay and of job interest, the National

Health Service is a strong competitor in the market for women workers without formal qualifications, and that in general the National Health Service should be able to recruit enough aides over the next seven years to meet this target and even possibly other targets as well.

665. Study of the prospective rate of growth of the labour force also suggests that the targets can be met, although the claim on overall growth will be a heavy one. In the short term, over the period 1971 to 1976, numbers of nursing and midwifery staff are expected to grow at the most by fourteen per cent in hospitals and twelve per cent in the community. During the same period we estimate that the extra staff required for the implementation of our recommendations will take up about half of the total growth in the nursing and midwifery labour force. At the end of the decade, when a new programme of education has been completely introduced, our proposals could initially take up to three-quarters of the total expected growth.

666. Our education proposals, with their emphasis on a broadly based education for all students, may lead to fears of staff shortages being experienced in those specialist fields into which students are at present recruited directly. Among these, midwifery stands out, and we have given careful consideration to the possible implications for the staffing of the maternity service arising from the changes we propose. A requirement for basic nurse training for all midwives could act as a deterrent to some of the five per cent of present entrants without nursing qualifications. The combination of a single-period course for all midwifery students (a recommendation which merely reflects existing trends) and a wider range of opportunities in the various fields of post-Registration specialisation could well reduce the numbers anxious to obtain a midwifery qualification as a means of enhancing their career prospects either in this country or overseas. We are also advocating that nursing should make greater efforts to attract men into its ranks, and this, coupled with the possibility of a reduction in the number of immigrant nurses, could well lead to a diminution in the number of potential recruits to midwifery departments. A fall in the numbers of midwifery trainees can already be observed as a result of existing policies. We do not expect any similar fall in the number of practising midwives.

667. On the other hand, we believe that midwifery is an attractive proposition for the mature entrant and we are hoping to recruit more entrants in the older age groups. We are also recommending that more student nurses should take obstetric training than at present; and while there is no evidence that they are any more likely to take up midwifery than those who are not so trained, they will in themselves be of some assistance in staffing maternity departments. The employment of Certificated nurses in maternity departments in support of the midwife should also be of assistance. On balance, while we can foresee problems in this area, we do not think that they are insuperable.

668. Paediatric nursing is another field where the changes we propose may cause some concern. As we pointed out in Chapter IV, the introduction of a comprehensive training programme is fully compatible with the preparation of nurses specially skilled in the care of sick children. We hope most nurses during their education will gain experience with this age group; some will gain a substantial part of their experience in sick children's hospitals or wards and, in addition,

they may have a period (rare at present for the registered sick children's nurse) with mentally ill or handicapped children and with children being cared for at home. Thus, the number of students in paediatric wards will, if anything, increase; the number of qualified nurses whose education will be concentrated in this field can be determined in accordance with current needs and there will be new opportunities beyond those existing at present to pursue the subject at Higher Certificate and advanced levels.

669. We have already discussed in Chapter IV the prospects for the three remaining specialties to which there is direct entry at present—ophthalmic, orthopaedic and thoracic nursing. We believe that the lowering of the age of entry which we propose will deprive the direct entry courses of one of their chief attractions. At the same time, however, we envisage students continuing to care for patients in all three areas as part of their basic training, with the possibility of specialising in one of these fields thereafter. The present separate schools will be encompassed within the broader span of the College, and it will be a particular responsibility of the Colleges, in conjunction with the service authorities, to ensure a smooth flow of students through all the specialist areas within their ambit and an adequate supply of newly qualified staff with the appropriate preparation to maintain and enhance existing standards of care.

670. We have also examined the meaning of change in some detail for hospitals in two provincial towns and London. In the provincial towns our conclusions are that replacement staff can be recruited over a seven-year period without much difficulty. There will be problems in London, as we point out in paragraph 673 below.

671. In general, our conclusion is an optimistic one in manpower terms. The service can make up for the reduced service contribution of trainees in most parts of the country, although success in meeting future targets will require a more coherent recruitment policy than in the past from most hospitals.

672. Hospitals will have to look at shift systems, the use of part-timers and conditions for non-resident staff, such as changing facilities. They will have to look at methods of recruitment and, as was suggested in Chapter V, at the appropriate inducements to recruitment, among them transport.

673. Our suggestions on personnel management are designed to help with the processes of growth. But there are qualifications. First, there will certainly be great difficulty in recruiting replacement staff for the teaching hospitals in Central London. Difficulty has already been experienced by the one hospital with an experimental scheme for modular training. We consider that vigorous and realistic recruitment policies may produce some success, but it may be necessary to have a larger number of trainees so as to maintain the service contribution than would otherwise be desirable. Second, will it be possible to recruit enough lecturers? The numbers of qualified tutors in England and Wales increased from 1,171 to 1,648 between 1963 and 1971; in Scotland the figures were 126 and 196. We have made it clear that special efforts are essential here, and our specific proposals are to be found in Chapter IV. Third, what will be the effect on the psychiatric and geriatric hospitals? In our view, this will certainly be positive. Such hospitals will gain in terms of service contribution, and our proposed scheme of education

will, we hope, help their recruitment in the longer term. Fourth, what will be the effect on community nursing? Here the main difficulties will be getting enough work experience for all trainees and the burden of supervision on community staff. But these problems will be small in relation to the benefits both to those taking part in teaching and to students.

674. Overall the proposals do not pose insuperable manpower problems for nursing or midwifery. However, they may well cause local problems where recruitment is already difficult. It is vital that all difficulties be brought to light at an early stage and faced realistically. They will provide a major and early test of the competence, ingenuity and imagination of some Districts and Areas. But the national authorities must help in making sure that areas of difficulty receive extra funds and resources.

675. One implication of our education proposals is that aides will increase as a proportion of the labour force even more than would otherwise be the case. Aides may be as much as one-third of the labour force in non-psychiatric hospitals by the end of the decade. Our proposals for the training of aides are not a frill or an afterthought, but a vital part of the total training effort. We started, after all, from the assumption that it is essential to create a more balanced nursing and midwifery work force.

676. We realise that the increased resources required by our proposals will have to be weighed alongside other claims on national resources, not least in connection with nursing and midwifery expenditure itself; for example, a shorter working week and increases in pay. In the course of our work, questions of pay have inevitably been raised with us—they cannot realistically be left out—and we are fully conscious both of the impact that such questions have on the subject of our enquiries and of the implications of our own recommendations on patterns of pay. Nevertheless, pay as such, and all other Whitley matters, are clearly outside our remit, and we have not attempted to make any direct recommendations on these subjects.

ASSIMILATION

677. Not all the problems of change are economic. There are psychological problems also. Nursing and midwifery face many different kinds of change, and even where change is for the better it inevitably leads to pressure and to anxiety. We have indicated at various points in our Report how we see the nurse and midwife of the present not so much fitting into the pattern of the future as helping positively to create it. Uppermost in our mind have been two considerations; the need to enhance the quality of patient care and the need to maintain equity between nurses and midwives with different backgrounds and preparation for their work.

678. The basic safeguard of patient care in a period of development of policies and structures is that all nurses and midwives should have received sufficient instruction to enable them to carry out their duties in a given situation and to recognise for themselves those circumstances which demand more highly-skilled help than they can provide. In practice, safety of patient care depends on the level of responsibility at which the nurse or midwife is working and the degree of supervision available.

679. During a period of transition, equity between nurses and between midwives has certain historical complications. Considerable discrepancies already exist as between Scotland and England and Wales. What appears equitable to nurses or midwives from one country will not necessarily do so to those governed at present by different rules. Equity cannot be based, therefore, simply on existing differentials. Those responsible for working out detailed arrangements to implement the recommendations in this Report should attempt to ensure that the following conditions are met if at all possible:

- (a) that under the new system no nurse or midwife is worse off than she or he is at present in terms of status in her or his existing field of work;
- (b) that prospects of progression and transfer are maintained or enhanced so far as is consistent with patient safety and that any additional training required for their work should not involve loss to individuals;
- (c) that recognition is accorded to past training and experience;
- (d) that subject to any necessary refresher or back-to-nursing training, such recognition applies without limit of time.

680. Assimilation, i.e., the matching of positions and qualifications held under the existing structure to those of the new structure, falls into two main categories, that of grades and that of qualifications. Our proposals will affect grading in four main areas; at ward/field level, where clinical skills above ward sister level are concerned, in top management and in teaching. The problems of assimilation at top and senior management levels arise rather from the process of National Health Service reorganisation than directly out of our recommendations and will be for others than us to resolve.

681. We emphasise, however, that consideration must continue to be given in decisions on the grading of such posts to the presence of trainees in the area for which the nurse or midwife is responsible. The creation of a separate teaching structure does not and should not absolve the service staff of any commitment to educational goals; nor should the reverse be true. As we have stressed, teaching and service are interdependent and contribute to each other. This is now recognised in some cases within the Whitley structure by means of pointage systems or differential salary scales. Whatever system is adopted, the principle of recognition must be maintained.

682. Even in respect of those grades which are directly affected by our proposals, it would be wrong in general for us to try to pre-empt the discretion of the new statutory body and other interests concerned in working out detailed proposals. The suggestions which follow are not intended, therefore, as rigid rulings but rather as points for future consideration.

683. Our proposals for grading structure at ward and community team levels are set out in Chapter II. We see the relationship between present and future structures at this level as follows:

(a) *The Ward Team*

Present Structure

Ward Sister

Future Structure

Ward Sister

*Present Structure (cont'd)**Future Structure (cont'd)*

Deputy Ward Sister (Psychiatric field only)	}	Senior Staff Nurse
Staff Nurse/Senior SEN		Staff Nurse (Registered or Certificated)
Enrolled Nurse		
Trainee ¹		Trainee ¹
Auxiliary		Nursing Aide

(b) The Community Team at Field Level

Health Visitor	Family Health Sister	} Equate with Ward Sister in hospital
District Nurse	Family Clinical Sister	
Domiciliary Midwife	Midwife	
Registered Nurse	Registered Nurse (including in future some Higher Certificated nurses gaining experience before promotion).	
Enrolled Nurse	Certificated Nurse	
Trainee ¹	Trainee ¹	
Ancillary Staff (Nursing)	Nursing Aide	

684. We consider, as we argued in Chapter VI, that clinical skills above the existing ward sister level should be recognised by enhanced status and reward within the grade or by promotion to Nursing Officer within the same job as appropriate, by the creation of joint teaching, research and clinical posts and by the creation of special staff posts at various levels in, for instance, clinical research. This is a matter of the recognition of existing expertise and the development and recognition of new scope for expertise. Individual circumstances will dictate levels of assimilation.

685. Our proposals for the future structure of nurse and midwife teaching are set out in Chapters IV and VI. A new top post of Principal coordinating all basic and post-basic teaching in all settings is envisaged. The posts of lecturer and clinical tutor are discussed in paragraphs 703–705 below. The structure of posts above this level will depend on the organisation and grouping of particular Colleges. In many cases there will be straightforward assimilation to an obviously equivalent grade and in many others promotion will be involved. There will also be instances when salary protection is required for individuals whose present post disappears. We expect that the increased career prospects in teaching will make such cases rare and likely to arise mainly where the individual concerned is not geographically mobile.

686. Turning to the question of assimilation of qualifications, we have proposed two statutory levels of qualification: Certification and Registration. In addition, there will be recognised Higher and advanced qualifications and there will be separate Registration for midwives. We outline below how the widely varying qualifications which now exist could fit into the new structure. A summary in tabular form is given as part of our summary of recommendations.

¹ The term "trainee" has been used for convenience to denote anyone whose presence in the team is primarily for the purpose of their own education.

687. At the present time three broad categories of enrolled nurses can be identified; nurses enrolled "by experience", who may in extreme cases have spent their entire careers doing night duty in one ward, nurses enrolled "by training" and enrolled nurses who have undertaken additional training, ranging from brief post-enrolment courses to recognised qualifications in, for instance, district nursing, midwifery, ophthalmic, orthopaedic or thoracic nursing. All enrolled nurses should in our view be accepted as Certificated nurses in the area of their main experience, both on grounds of equity and on grounds of practicality. For many years to come they will continue to be a major part of the basic nursing work force.

688. Qualification for work as an enrolled nurse in a different setting requires further training at present in England and Wales, which may vary according to previous experience. In Scotland, no further training is required. However employing authorities can and do employ nurses as enrolled nurses in fields other than those in which they qualified. We have noted that, while preparation for Certification should normally include experience in all major settings, it will not always be possible to include such experience during the transitional period. Since the course is designed to teach basic principles of nursing which are applicable, with minor variations, in all settings, we do not propose that transfer should be restricted on the grounds that experience in the relevant setting was not gained during basic training. We emphasise, however, that in-service training should be given wherever required.

689. The transitional problem resolves itself into seeking a compromise between the extremes of the English/Welsh and Scottish patterns which will take full account of the pattern of the future. Clearly, the training and experience already undergone must exempt enrolled nurses from repetition of the module or modules relevant to their area of main experience, and also from the whole experience requirement. The *maximum* amount of additional formal training which theoretically could be imposed in order to achieve full transferability would therefore be two modules (i.e., psychiatric and community) in the case of enrolled general nurses and three (i.e., general, surgical and community) in the case of enrolled psychiatric nurses. Transfer within the hospital field would require a *maximum* of one and two modules respectively. We suggest that transferability of qualification within the hospital field should be permitted after a minimum of a period of in-service induction training and a maximum of two modules plus induction training. Transfer to the community would require a minimum of one and a maximum of three modules, plus induction training. Variation within these limits would depend on previous training and experience and the field to which it was desired to move. This would apply both to nurses enrolled by experience and nurses enrolled by training.

690. Post-enrolment training should be taken into account in determining the need for further training on transfer. Of the recognised qualifications now obtainable by enrolled nurses, we suggest that district nursing should be recognised as the equivalent of a community module, and midwifery as entitling to Registration as a midwife. Ophthalmic, orthopaedic or thoracic training might count towards a reduction in the training period for Registration. Additionally they would confer career advantages in the same way as other non-statutory specialised training courses.

691. Under our new education proposals, Registration can be acquired by Certificated nurses after seventy-eight weeks' controlled clinical experience including successful completion of three modules in any area. This compares with 104–130 weeks for enrolled nurses wishing to proceed to registration at present. A case can be made out for abbreviating, retaining or extending the seventy-eight week period for Registration in the case of enrolled nurses. The case for abbreviation is that their training (and probably also experience) has been longer than the training of Certificated nurses. The case for extension is that a full, and not a limited, Certificate should be acquired before embarking on training for Registration; this could mean the addition of a thirty-nine week training period to the seventy-eight week pre-Registration course, though in most cases the additional training would be twenty-six weeks or less. The case for retention is that the arguments for abbreviation and extension cancel out.

692. We suggest that in order to proceed to Registration enrolled nurses should first achieve full Certification. The Registration course could then be taken in a period shorter than seventy-eight weeks, to be determined in accordance with the following criteria:

- (a) the total number of modules successfully taken, including those required for full Certification, should not be more than six or less than three;
- (b) post-enrolment courses might count and courses leading to nationally recognised qualifications, e.g., district nursing, ophthalmic, orthopaedic and thoracic nursing, should count towards the completion of relevant modules;
- (c) past experience should be recognised by the statutory authorities as contributing to the clinical experience requirement.

Registration would be subject, of course, to the normal requirement under our education proposals that nurses wishing to practise at Registered level in fields where their experience was limited would need to take one or two additional modules.

693. The position of the present registered nurse is much more complicated. There are at present five categories of registered nurse—general, sick children's, mental, mental subnormality and fever nurses. Transfer to another part of the register requires from fifty-two to 104 weeks' additional training, depending both on previous and intended future registration, and on whether the qualification sought is Scottish or English/Welsh. Moreover, we do not merely have to consider five types of registered nurse for assimilation. Many nurses have dual and some triple registration or more. It has also to be borne in mind that although registration in a new field is subject to conditions laid down by the General Nursing Councils, as in the case of enrolled nurses mentioned earlier, employing authorities can and do employ nurses at registered level in a field inappropriate to their qualification.

694. Our education proposals provide that all future Registered nurses will have been Certificated, but because of the existence of separate parts of the register and, in England and Wales, of the roll, all present registered nurses are not eligible for enrolment. In order to be recognised as an enrolled nurse for any one part of the roll other than the field in which she is registered, a registered nurse must undertake twenty-six weeks' training in the new field in England and Wales

or fifty-two weeks in the case of the registered fever nurse seeking enrolment in the general field. In Scotland the question does not arise as there is no division of the roll. Unless Registration without limit is conferred on all present registered nurses, the case could arise of a registered nurse wishing to work in a field other than that of her or his registration, and not prepared to undergo training for transfer. Should such a nurse be accepted as a Certificated nurse without further training? We suggest that in these rare cases the candidate should be allowed to take the relevant final modular assessment for Certification without undergoing the module(s). Nurses who passed would be allowed to practise as Certificated nurses. If they failed, they would have to do the module(s), and in this case, their best course would probably be to take those modules recommended for practice as a Registered nurse in that field.

695. Apart from registered fever nurses (whose special case is discussed separately below), all registered nurses should be recognised as Registered in the field of their main experience. We suggest that transfer arrangements should be the same as those envisaged for nurses Registered under our new education proposals, all of whom will have to complete at least one module on transfer to a field which has not been a primary choice. Some will be asked to do a second module to correct imbalances in their training, and this provision will probably apply to most of the existing singly registered nurses with the exceptions suggested below. Multiple qualification should count towards the reduction or elimination of the training required for transfer where appropriate (e.g., district nursing might count as the equivalent of one community module). In most cases the time required to achieve a dual qualification will have been a great deal longer than will in future be needed to satisfy the transfer requirement. As well as being counted towards transfer, therefore, consideration should be given to counting training for a second or subsequent part of the register as the equivalent of specialised post-Registration training which, although not statutorily recognised, would have career advantages. In some cases, a second qualification might count as the equivalent of a Higher Certificate. Ophthalmic, orthopaedic and thoracic training and specialised post-registration trainings might count as the equivalent of future specialised post-Registration courses, Higher Certificates or advanced courses as determined by the statutory authorities; midwifery should be regarded as a Higher Certificate. They would also be taken into account in assessing modular requirements for transfer.

696. Registered fever nurses present special problems, since the only field in which they can practise as registered nurses at present is the small and shrinking area of infectious diseases. Such nurses must do seventy-eight weeks' extra training in England and Wales (104 weeks in Scotland) to qualify for another part of the register. All other registered nurses can fairly readily be equated with nurses achieving Registration under our new educational scheme, but fever nurses cannot. We suggest that their registration continue to be recognised in the field of infectious diseases, and that transfer within the hospital field should normally require two modules, subject to remission in respect of any relevant experience, and three modules for transfer to community nursing. It can be argued that since their training for registration lasted 104 weeks, transfer arrangements should be equated with those for enrolled nurses. Fever nurses are, however, treated like other registered nurses for transfer at present, and we have seen no evidence suggesting that this arrangement is unsatisfactory.

697. Nurses who have successfully undertaken the 104 weeks' thoracic training may at present practise at staff nurse level in chest hospitals. Fifty-two weeks' additional training is required for enrolment and 143 weeks for registration. We suggest that these nurses should be recognised as Certificated nurses in the field of their specialty, and should be required to complete one further module and an element of experience on transfer to either general or psychiatric nursing at Certificated level and two modules plus an element of experience on transfer to community nursing at Certificated level. This means that their previous training should count for remission of one general module and part, but not all, of the experience requirement. Since some ward sister and senior staff nurse posts may in future be held by Certificated nurses, this proposal need not damage the immediate career position of BTA nurses, and would improve their long-term prospects.

698. All nurses with community qualifications are already registered or enrolled nurses and the same arrangements for recognition and transfer of their basic qualification would apply as with other nurses. We have suggested above that qualified district nurses should count as Registered or Certificated nurses who have fulfilled the full community requirement, and qualified health visitors should receive similar recognition. In addition, qualified health visitors should be regarded as at least equivalent to family health sisters with a Higher Certificate in preventive nursing, since all will have had at least fifty-two weeks' specialised post-registration training.

699. We do not suggest that all district nurses should be regarded as holding a Higher Certificate in community clinical nursing. Their training has been shorter than that of health visitors and we see a need to distinguish between those who by virtue of experience, ability and possibly additional training are already at Higher Certificate level and those who need further training before they can be regarded as suitable for the Higher Certificate. An objective means of distinguishing between these nurses is needed, and we suggest as a possible solution to this problem that district nurses should be recognised as Higher Certificated if they have had a prescribed period of experience and can pass an assessment showing their ability to function as leaders of the clinical community team.

700. It follows from what we have said above that midwives who are already enrolled nurses should be regarded as fully qualified midwives with a nursing Certificate limited to the field of their main experience. Conversion of the Certificate could be achieved in the same way as for other enrolled nurses granted limited Certificates, and the midwifery training and experience should be taken into account in setting modular requirements for transfer.

701. Similarly, midwives who are registered nurses should be regarded as fully qualified midwives with nursing Registration susceptible to conversion in the normal way, with some recognition of the value of the midwifery training and experience undergone.

702. Midwives with a non-statutory nursing qualification and midwives with no nursing qualification should be regarded as full midwives but not as Certificated nurses. Some reduction should be allowed in subsequent training for

Certification in respect of the qualifications already held; it might be possible, for instance, to remit part of the modular community and general nursing requirements and some of the experience requirement.

703. Given the need to increase the teaching work force, assimilation arrangements for teachers are of paramount importance. Future full teaching grades will rest on a three- to six-month course for clinical tutors and a one-year course for lecturers. A senior lecturer who has qualified as a lecturer should preferably have additional qualifications. We suggest that in the immediate future, senior lecturers should be drawn from those assimilated with a lecturer qualification, particularly those with further education of a relevant kind.

704. There is a wide range of teaching posts at present, as well as considerable differences in preparation even for nominally similar posts. We suggest that assimilation take place as follows:

(a) the following groups should be considered for acceptance in the lecturer grade, bearing in mind that some will be able to teach in a wider field than others:

- (i) all existing registered nurse tutors;
- (ii) all existing recognised health visitor tutors;
- (iii) all nurses who hold teaching qualifications recognised by the Education Departments, subject to a nursing experience requirement;
- (iv) all midwife teachers holding the Midwife Teachers Diploma;
- (v) district nurse tutors at the discretion of the statutory body;
- (vi) other individuals (e.g., those with foreign qualifications) at the discretion of the statutory body and the Health Departments;

(b) the following groups should be considered for acceptance in the clinical tutor grade, again bearing in mind that some will be able to teach in a wider field than others:

- (i) all existing registered clinical teachers;
- (ii) all nurses holding the City and Guilds Teachers Certificate No. 394 or 395 or the London University Diploma of Nursing in Clinical Teaching, subject to a nursing experience requirement;
- (iii) district nurse tutors not eligible to become lecturers, and clinical instructors in midwifery (Scotland only);
- (iv) other individuals at the discretion of the statutory body and the Health Departments.

705. Three groups with teaching responsibilities present difficulties—practical work instructors in district nursing (which is not technically a recognised grade), midwives with recognised teaching responsibilities but no formal teaching qualification, and field work instructors in health visiting, whose teaching course has lasted only thirty days. We suggest all three groups may be suitable for the kind of joint appointment in teaching and clinical practice which we envisage for the future (see Chapter IV); they could also qualify for some remission in a clinical tutor course.

706. The timing of many of these changes will depend on the speed with which legislation can be brought in to introduce the new qualifications. Some changes, however, do not depend on legislation. The grading structure we envisage, with increased recognition of clinical responsibilities and a different approach to teaching, should be introduced as particular posts are created within the new pattern. Some nurses and midwives are already acting in a consultant capacity to their colleagues or are carrying out clinical research, and we see no reason to delay formal recognition of their special position, although we recognise that on this as on other matters, there must be negotiation between professional and service interests. The new teaching staff structure is designed to meet the needs of the new pattern of Colleges of Nursing and Midwifery which will be bigger and have wider responsibilities than the present schools of nursing or midwifery.

707. Although we hope that there will be an acceleration of the present trend towards grouping of schools, Colleges of Nursing and Midwifery in their final form cannot emerge until integration of the National Health Service becomes a reality. We recommend that "shadow" appointments be made, both in teaching and in administration, before the appointed day, so that policies and programmes can be developed in anticipation of the change.

708. In some of the evidence we received we were urged to recommend experiment before embarking upon new forms of education. We believe, however, first, that there have already been enough experimental schemes (not least those involving modular patterns) to demonstrate both the hazards and the advantages, and, second, that changes as far-reaching as those we are proposing cannot fully be tested in advance. Transition from a system of separate modes of entry and training to a unified system based on the concept of a continuous educative process is something which cannot be piloted. It represents a fundamental change. Legislation will be needed to implement some of our proposals, and it should be introduced and carried in time to enable the full programme which we are recommending to be introduced five years from now.

709. We recognise that for some time to come, all the types of experience which we should like to see included in nurse and midwife education will not necessarily be available to all students. We believe, however, that there is enough flexibility in the courses we propose to allow for wide adaptation to meet transitional needs.

710. The need for legislation is not the only factor influencing our suggestion that full implementation should come some years ahead. If the new scheme is to succeed, as we believe it will, given the right conditions, there is much ground-work to be carried out. As a matter of the utmost urgency, a major programme to increase the nurse and midwife teaching strength should be launched. By this we do not mean simply the necessary introduction of more tutor courses. The content of the courses and the conditions relating to them should be very carefully reviewed. Excessive rigidity over entry qualifications should be avoided, and imaginative and vigorous schemes must be prepared to assist the present unqualified tutors to gain a recognised qualification. Most of the courses should be on the lines of the one-year courses now running at Bolton and Wolverhampton, which concentrate on developing the teaching skills of nurses whose clinical

skills have already been enhanced in other ways. Short peripatetic courses should be mounted to ensure that opportunities are available in different parts of the country, and the possibilities of part-time, evening and correspondence courses should be fully exploited. Courses for clinical teachers should be extended, and ward and field staff who encounter trainees should be adequately prepared through short courses, seminars, lectures and discussions to carry out their teaching responsibilities.

711. Increasing the teaching strength is all the more important because, in addition to the demands of our new education scheme, we are suggesting lowering the age of entry to nursing. To soften the impact on schools and to spread out the once-and-for-all increase in recruitment which we expect to result from the change, we propose that the change should be phased, with a fall to seventeen and a half in 1973, the year in which the raising of the school leaving age will increase competition for young entrants; and a further fall to seventeen should be planned for in 1975, by which time the first 1973 entrants will have spent two years in the profession. Even phased, and timed to coincide with a period of difficult recruitment, the entry of younger trainees in larger numbers will undoubtedly place a burden on the training institutions and there must be an increase in the teaching strength for this reason alone.

712. Additional and better-trained teachers are only part of the support needed to secure the future of nurse and midwife education. We have referred earlier to the need to ensure that students' clinical experience is a genuine learning process. We are fully conscious of the tremendous adjustment that this will involve. There will be a clear need for additional nursing and midwifery staff in order to support and release students; some must be qualified staff, but there will also be scope in many places for a fuller use of nursing aides working under qualified supervision. We have discussed the scale of the requirement above. As a matter of priority, efforts should be directed towards improving retention rates and increasing the effectiveness of deployment through better conditions of work, revised and improved shift systems and off-duty rotas and a move towards organised systems of personnel management, occupational health provision and counselling facilities. Of particular importance in this context is an early move towards the approach to ward and field organisation which we discussed in Chapter II. Our proposal for an official agency system in nursing and midwifery should be pursued without delay.

713. For reasons set out in Chapter V, a national drive to bring mature entrants into and back to nursing and midwifery should be launched, together with back-to-nursing and midwifery courses and special training schemes. Our proposal that there should be a system for keeping in touch with nurses and midwives who have left the profession should be followed up immediately.

714. Overseas entrants are sometimes lost to the profession or never achieve their full potential because they have never received orientation training or the special support and advice they need. Proper induction programmes should be introduced without delay.

715. Similarly, although some nursing auxiliaries and assistants have received a modicum of training, our research shows that many have not. The national

introduction of minimum training requirements should not be delayed. The value of aides as members of the nursing or midwifery team will be greatly increased by appropriate preparation, and the time spent on in-service training will be repaid over and over by more informed and intelligent support.

716. While we consider preparation of the groundwork for our new scheme of education as being of paramount importance, we also regard it as essential that nurse and midwife education should not stagnate during the next five years. Much can be done to ease the transition to the new approach. In many parts of the country and particularly in Scotland, syllabuses are already becoming broader, and we believe that this trend should continue and accelerate. Similarly, we believe that modular patterns of education should be extended. We are aware of experiments in shortened forms of training for enrolment, and we recommend that such experiments should be extended and adapted on the lines of our proposed course for Certification. Where possible, it would be highly desirable, as in our own proposals, to make such courses the basis of a three-year programme leading to registration. The powers of the existing General Nursing Councils to experiment would, we believe, permit this, and the experience so gained would be invaluable at the stage of universal implementation. We hope that as many such schemes as possible, with at least twelve in 1973 and 1974, will be launched during the interim period before full implementation.

717. We also hope that degree courses will continue to expand and that universities and other institutions of higher education will take note of our views on the subject as outlined in Chapter IV. Unless universities, polytechnics and other institutions are given encouragement and the financing of student participation in such courses is properly organised, it will not be possible to increase the graduate element in the nursing and midwifery profession as we are recommending. The planning of such courses must be fully discussed between institutions of higher education and the professional bodies in order that there is no waste of resources.

718. The setting in which education takes place has already been changing with the grouping of schools and the closure of some small schools. It is important that these changes should continue at an accelerated pace in order to minimise difficulties in creating Colleges of Nursing and Midwifery to coincide with the reorganisation of the National Health Service in 1974. Where links do not exist between schools offering different branches of training, and where there are no links between hospital schools and local authorities, they should be forged. Change on the scale we envisage is bound to be traumatic for particular individuals at a time when other major changes are impending, and everything must be done to smoothe the way ahead. It is important to note in this context that our concept of a College allows for the continuation and in some cases the extension of "outstations" where teaching is carried out, as well as for the movement of students through a variety of clinical settings. Absorption of a school into a College will not mean loss of students to the hospital or hospitals concerned, and the work of the teaching staff will increase rather than diminish, within a more favourable educational and professional environment.

719. It is of the utmost importance that the nursing and midwifery profession should be fully involved in and lead the movement for educational reform. For

this reason, we regard the restructuring of the statutory bodies controlling nursing and midwifery education as one of our chief priorities. We recognise that there must be an initial period of discussion before changes of such far-reaching importance are made, that the precise composition of the bodies must be settled and that legislation will be needed to secure the new structure. Subject only to such essential delays, the new statutory bodies should be brought into being with the utmost urgency, in order to exercise a guiding influence on the reformulation of nurse education.

720. We believe also that there is an important and growing role for the professional associations and trade unions which have done so much to improve conditions both for nurses and midwives and for patients. As we indicated in Chapter VI, paragraph 598, membership is relatively low at present. We hope that in the future more nurses and midwives will take part in the activities of these bodies. They offer creative opportunities for nurses and midwives to participate in policy making at different levels. If the unity of the profession is to be strengthened, there must be even fuller communication between different professional associations. Many of them have carried out intensive studies before presenting evidence to our Committee, and are fully aware of the significance of the issues with which we are concerned in this Report.

721. Reference has been made at various points in this Report to the need for a strengthening of personnel, counselling and occupational health functions. These are all fields in which National Health Service staff as a whole are involved, and, whatever specific preparatory moves are made in relation to nurses and midwives (and we have indicated that these must be energetic), the timing of full implementation must be seen as part of the management development of the National Health Service as a whole.

IMMEDIATE ACTION 1972-74

722. We envisage, then, a period of intense activity over the next five years, culminating in full implementation of our proposals. The General Nursing Councils, and, where relevant, the Central Midwives Boards, supported by the Central Departments, should introduce immediately a massive programme of extension and enhancement of teaching skills, should encourage and support schemes of training for mature entrants and re-entrants and should group schools and establish training schemes on the new pattern under their existing experimental powers. In collaboration with staff interests, the Health Departments should provide guidance on how to secure better conditions of work, including the organisation of hours of work, and should both encourage the establishment of personnel, counselling and occupational health services and make provision for appropriate training to be available for nurses, midwives and others engaged in such services. They should continue and speed up the process which has already begun of giving increased recognition to clinical and allied skills, and work out the details of the new teaching staff structure. After appropriate consultation, the Health Departments should give guidance on training for nursing aides, should intensify recruitment efforts, particularly in relation to mature entrants, and should arrange discussions on the best way of introducing an official agency system in nursing and midwifery and establishing links with nurses and midwives who have temporarily left the profession. They should take action to set up the

manpower and personnel units proposed. Rules should be introduced enabling the age of entry to nursing to fall to seventeen and a half in 1973 and seventeen in 1975.

MIDDLE-TERM ACTION 1974-77

723. After the reorganisation of the National Health Service in 1974, personnel departments, counselling and occupational health services should begin to function formally. The new senior nursing and midwifery staff structure should be in full operation and following the necessary discussions between statutory, staff and employer interests Colleges should be ready to operate. The Health Departments should have completed consultations and introduced legislation to set up the new statutory bodies which we recommend, and these bodies should be involved in urgent consideration of detailed future education programmes for both students and teachers. Rules setting out entry requirements, education syllabuses, assimilation conditions and so on should be prepared for implementation by 1977.

LONG-TERM GOALS—QUALITY THROUGH GROWTH

724. The five-year plan outlined in the preceding paragraphs marks only the beginning of a process. However difficult it is to peer far into the future, we have tried to take account in all our thinking of long-term objectives and perspectives.

725. During the final decades of this century, there will, in our view, be a more comprehensive and unified approach to health care, with, at the same time, greater specialisation of particular services within an overall unity of control as the study of hospitals will concentrate increasingly on intensive treatment and crisis treatment of conditions of all kinds, and a strong supporting network will be created in the community. Alleviation and continuing care will always be necessary, but there will be major developments in positive health with explicit prevention, rehabilitation and social (including population) policies. There will be further technological changes, some of which could be far-reaching.

726. Throughout our Report, we have stressed the variety that already exists within nursing and midwifery, and we have tried to show that, however haphazardly that variety has come about, it has always done so in response to human needs. An integrated National Health Service will need a great deal of deliberate long-term planning, but it will be essential not to limit or straitjacket development, but to ensure that it continues to respond imaginatively to changing needs. The success of planning will depend on better information and forecasting systems and on regular lines of communication being opened between authorities responsible for service to patients and those responsible for nursing and midwifery education. It will also require purposeful and effective clinical research, deepening our understanding of the methods and objectives of nursing and midwifery care. Nursing must be a research-based profession.

727. Nurses and midwives have worked for many years in a climate of constant change. Their close relationship with the patient has not altered, and will not do so; but the settings in which they provide care and the processes of care themselves will continue to change, very probably faster than in the past. Nurses

and midwives being educated now and during the next ten years will be leaders of their profession when an integrated National Health Service will be taken for granted. It is for this reason above all that nursing and midwifery education must begin with first principles, common to all nursing and midwifery care, and must introduce nurses and midwives to the multiplicity of contexts within which they and their colleagues will work in the course of their lives. An awareness of the scope of the profession and the possibilities within it is an essential preparation for careers which must cross many borderlines traditionally held to be inviolable. Paradoxically, but not accidentally, the educational pattern we are proposing begins by emphasising the unity of care, yet goes on to allow far greater scope for individual specialisation than traditional separate specialised forms of training. All nurses and midwives will know that as far as is possible, they will have been provided in all new situations with the exact preparation which is needed.

728. The counterpart of a more sophisticated recognition of the needs of patients as individuals and as groups will be, we believe, a more sensitive appreciation of the needs of nurses and midwives themselves. Nursing and midwifery will always involve stress, strain and difficult work, and there must be a tough and sturdy framework within which nursing and midwifery teamwork can operate. Nurses and midwives themselves must be encouraged to chart their own future. It will be necessary to ensure that each individual nurse or midwife is given good guidance about careers as well as about education, and that the conditions of work and living are such that the positive attractions of nursing and midwifery to people of different talents are enhanced. Management must always be conceived of in the right way as the effective development of the full potential of precious human resources.

SUMMARY OF RECOMMENDATIONS

Our main recommendations are listed below. They should be read in the light of the fuller explanation given in the paragraphs cited.

(a) The statutory framework

1. There should be a single central body responsible for professional standards, education and discipline in nursing and midwifery in Great Britain—the Central Nursing and Midwifery Council. (618–623; 627; 632–639)

2. There should be three distinct Nursing and Midwifery Education Boards for England, Scotland and Wales, responsible to the Council. (624–625; 627; 631–632; 634–639)

3. Midwifery interests should be represented by a statutory Standing Midwifery Committee of the Council. The Committee would advise the Council and Boards on midwifery education and have direct control of midwifery practice. (626–629)

4. Below the three Education Boards there should be Area Committees for Nursing and Midwifery Education. (640–648)

5. Responsibility for nursing and midwifery education should remain with DHSS, SHHD and WO. (649–650)

(b) Education

6. Education should be regarded as a continuing process under unified control. (253–255)

7. Colleges of Nursing and Midwifery should be established throughout the country financed through the Area Committees for Nursing and Midwifery Education. (346–348; 354–355)

8. The feasibility of setting up a number of Colleges of Health Studies should be explored. (362–363)

9. Each College of Nursing and Midwifery should have a governing body with powers similar to those of governing bodies in institutions for which local education authorities are responsible. (349–351)

10. Each College should be under the direction of a Principal with the assistance of a Vice-Principal (where necessary) and of lecturing and tutorial staff. (352–353)

11. There should be close liaison for recruitment purposes between the Colleges and schools and the youth employment service. (260)

12. There should be an increase in the number and range of pre-nursing courses, with nursing cadet schemes continuing as part of that range, under the title of Preparation for Nursing Courses. (261–265)

13. At the point of entry to the nursing and midwifery profession, applicants should be drawn from a wide range of intelligence from average to the highest. Suitability should not be determined by O levels alone. (259)

14. The age of entry should be reduced in two stages to 17½ in 1973 and to 17 in 1975. (266–268)

15. There should be an annual national publication listing educational institutions and courses similar to the King Edward's Hospital Fund for London Schools of Nursing Directory. (269)

16. There should be one basic course of eighteen months for all entrants which would lead to the award of a statutory qualification, the Certificate in Nursing Practice. (270–281)

17. Courses should be planned on a modular basis and should include experience in general and psychiatric nursing of the various age groups in both hospital and community. A defined amount of night duty should be part of the student's curriculum for its educational value only. No un-Certificated nursing student should be left in charge of a ward at night and there must be proper support at night and at week-ends in the clinical learning situation by teachers and senior staff. (267; 270–284)

18. The eighteen-month course leading to Certification should be common to both prospective nurses and prospective midwives. (303)

19. A further eighteen-month course, also on a modular basis, and open only to those holding the Certificate in Nursing Practice, should be provided. It should lead to a second statutory qualification, Registration. The new Register, unlike the present register, should not have separate parts. (285–300)

20. For the more able students courses leading to Registration could include or be followed by courses leading to the award of a Higher Certificate (non-statutory) in a particular branch of nursing or midwifery. (285–287; 296–300)

21. There should be two ways of becoming a midwife:

(a) following Registration as a nurse: a twelve-month course leading to Registration as a midwife and the award of a Higher Certificate;

(b) following the Certificate in Nursing Practice: an eighteen-month course leading to Registration as a midwife and the award of a Higher Certificate. (303–307)

22. Examinations for the statutory qualifications of Certification and Registration should be supervised by the three Education Boards who should use panels of external and internal assessors. The Boards should make a close study of assessment and examination techniques. (308–310)

23. The Education Boards should consider the best forms of educational provision (a) for graduates entering nursing and (b), in conjunction with universities, for students wishing to combine nursing with a degree. (312–318)

24. Special training provisions should also be made for mature entrants: these should take account of their domestic commitments. (319–322)

25. Nursing students recruited overseas should be screened in their own countries wherever possible, and before beginning training they should be given effective orientation courses. (323–326; 714)

26. Post-Registration courses, including clinical refresher courses, should be organised by the Education Boards as part of the on-going educational process. (327–333)

27. There should be more "back-to-nursing" and "back-to-midwifery" courses for qualified returners and "keep-in-touch" courses for non-practising qualified nurses and midwives who might subsequently return. (335)

28. There should be a planned in-service training scheme for nursing aides. The scheme should be based on a nationally agreed syllabus. (336-341; 715)

29. Students should continue to receive training allowances, which should be channelled through Area Education Committees, rather than student grants. (360-361)

30. Nursing and midwifery education should include an introduction to the work of related professions such as the professions supplementary to medicine, and social work. (364-367)

31. Educational and financial provisions must be made in order that the nursing and midwifery profession shall become more research-based. (370-378)

32. There should be improved continuity and coordination of education in classroom and service, with greater involvement of teachers in the service setting and the use of, for example, clinically expert ward sisters and their community equivalents in Colleges. (353-354; 356-358; 391)

33. It should be possible for people on the teaching staff of Colleges to hold honorary appointments in the service setting and vice versa. (353; 356; 391)

34. Teachers of nursing and midwifery must be adequately prepared. They should no longer be required to teach all subjects in the syllabus. The basic qualification for teachers should be a one-year course for the Diploma in Nursing and Midwifery Education. (383; 392-395)

35. There should be a major drive, started as quickly as possible, to produce more nursing and midwifery teachers. (379; 396; 710)

36. In liaison with the Education Departments, the Health Departments and the Central Council through its Education Boards should plan urgently a ten-year programme to increase the number of those holding the Diploma and to qualify more teaching staff generally. (396-398)

37. There should be refresher courses for teaching staff, taking account of newly identified needs as they arise. (399)

(c) Manpower

38. Efforts should be made to increase male recruitment. (414-415; 435)

39. Increased training facilities should be made available to mature entrants. (319-322; 433-434; 713)

40. Special attention should be devoted to the recruitment of more A level, undergraduate and graduate entrants. (259; 312; 316; 318; 436)

41. Steps should be taken to encourage nurses and midwives whose careers are interrupted to return to the profession. (335; 438-441)

42. Methods should be devised to ensure that health authorities can keep in touch with qualified nurses and midwives who cease to practise. (441)

43. Manpower and personnel departments should be set up at regional and central, Area Health Authority/Board level. They should be concerned with all categories of staff in an integrated National Health Service. (479; 499-511)

44. Within these departments help should be secured from specialists in disciplines such as labour economics, operational research and personnel management. (502)

45. Senior Nursing Officer posts should be created at Area Health Authority/Board level for nurses and midwives specially trained in the manpower/personnel function. (486)

46. As a matter of urgency, about one hundred people should be trained to fill these posts and a training programme should also be developed to fill long-term needs. (487-488)

47. Long-term and short-term objectives should be identified in order that the quality of patient care can be improved and resources can be used to the best effect. (490-493)

48. A comprehensive information system should be developed by the Health Departments in cooperation with the central training bodies and regional and Area authorities, and should include data on rejected applicants. (178; 500-501)

49. There should be closer liaison and more interaction between the Health Departments and those responsible for pay and conditions of service, training and personnel in the National Health Service. (512)

50. Detailed manpower and personnel policies should have a long-term dimension; in the interim, the Health Departments and the Regional Health Authorities should set minimum staffing ratios. (514)

51. There should be more use of discriminatory budgetary procedures not only to assist the worse-off areas to catch up, but also to help them match resources to needs. (515-518)

(d) Conditions of work

52. Where possible the long (twelve-hour) day should be discontinued. (574)

53. Serious consideration should be given to arranging permanent night shifts in suitable areas in preference to rotation, and the organisation should ensure adequate up-dating, continuity of care and interchange of experience. Shift organisers generally should try to strike a balance between service requirements and staff wishes. (570-575)

54. On-call systems should be reviewed and national agreement should be reached on a definition of the working week for community nurses and midwives. (576-579)

55. A network of comprehensive counselling services should be set up urgently, incorporating academic advice, career guidance and personal counselling. (580-592)

56. All nursing and midwifery staff should have access to an occupational health service. (593)

57. The implementation of appraisal schemes should be carefully negotiated with full consultation at local level. (595)

58. Personnel departments should, after consultation, devise a workable procedure for dealing with individual grievances. (596-600)

59. The principle of representation of nurses and midwives by a nurse or midwife should be generally accepted, and some form of industrial relations training should be made available to nurses and midwives. (600)

60. The powers at present vested in hospital authorities in certain circumstances to approve assisted travel schemes for staff within a fixed salary maximum should be extended to cover all grades. Car parking facilities for nursing and midwifery staff at hospitals should also be extended wherever possible. (605-607)

61. Assistance of the type already given to nurses and midwives wishing to be seconded for study to complete a university course should be extended to post-graduate as well as undergraduate courses. (608)

62. There should be a better general standard of accommodation, and there should be a designated officer generally responsible for staff accommodation. (609)

63. Supervision of nurses' residences should be kept to a minimum, and there should be no need for a home warden for qualified staff. There should be adequate provision of changing and rest rooms. (610; 613)

64. Authorities should give consideration to the provision of day nurseries and play facilities. (614)

(e) Organisation of nursing and midwifery work and career structures

65. Improved liaison between hospital and community services should be vigorously pursued. (546; 551-552)

66. Ward organisation should, like the organisation of field work in the community, be, where possible, "patient" rather than "task" orientated. (122-124; 133)

67. Cooperative teamwork and maximum delegation should be fostered at ward and field levels, and senior staff nurse posts should be created. (127-134)

68. Differences in degrees of responsibility and expertise among ward sisters and their counterparts in community nursing and midwifery should be recognised by increased status and reward. (541-542; 548)

69. There should be increased use of staff posts at various levels in both hospital and community nursing and midwifery in relation to (for example) personnel and research. (545; 554)

70. There should be a continuing distinction of functions and qualifications between nurses engaged in family clinical (home nursing) and family health (health visiting) services. (548)

71. Top nursing and midwifery administrative structures should build on present structures, and opportunities should be open to nurses and midwives from all fields to reach the top. (550-554; 556)

72. There should be a strong nursing and midwifery team at Area level with executive functions. (553)

73. The staff structure of the Colleges of Nursing and Midwifery should be separate from the service structure and the Principal of each College should be responsible through the governing body to the Area Education Committee. (555)

74. A new caring profession for the mentally handicapped should emerge gradually. In the meantime, in the training of nurses in the field of mental handicap, increased emphasis should be placed on the social aspects of care. (557-565)

(f) *Assimilation*

75. Assimilation arrangements should be negotiated in the light of the detailed education plans drawn up by the new statutory bodies. The guidelines for consideration given in Chapter VII are summarised in the following table. (677-705)

SUMMARY OF RECOMMENDATIONS: ANNEX

ASSIMILATION OF QUALIFICATIONS

<i>Existing qualification</i>	<i>Level of assimilation</i>	<i>Additional training for transfer</i>	<i>Total for full transferability</i>	<i>Any other points</i>
Enrolled nurse (general field)	Certification limited to general nursing	Maximum one module for each transfer	Minimum one module Maximum two modules (Certification)	enrolled nurses who had completed the training required for full Certification could proceed to Registration in less than the normal maximum of 78 weeks subject to completion of a minimum of three and a maximum of six modules since enrolment. Experience and certain post- or pre-enrolment courses (e.g., district nursing, ophthalmic, orthopaedic or thoracic nursing) to count for remission
Enrolled nurse (psychiatric field)	Certification limited to psychiatric nursing	Maximum two modules (hospital) or three (community)	Minimum one module Maximum three modules (Certification)	
Enrolled nurse working in the community	Certification limited to general and community nursing	Maximum one module (psychiatric)	Minimum induction training Maximum one module (Certification)	
Registered nurses except for fever nurses	Registration limited to field of main experience; Certification in other fields subject to satisfactory performance on assessment	As for Registered nurses under the new scheme	As for Registered nurses under the new scheme (Registration)	Multiple qualification to count for remission in transfer requirements, and as specialised, higher or advanced courses as appropriate
Fever nurses	Registration limited to infectious diseases; Certification in other fields subject to satisfactory performance on assessment	two modules for hospital and three for community nursing	Maximum five modules (Registration)	
BTA nurses	Certification limited to chest diseases	One module and an element of experience for each hospital transfer; two modules and an element of experience for transfer to the community	three modules and experience (Certification)	

HV	Registration limited to field of main experience: Higher Certificate in preventive nursing	As for other Registered nurses	As for other Registered nurses (Registration)	
DN	Registration or Certification limited to field of main experience: some to receive Higher Certificate in community clinical nursing subject to assessment	As for other Registered or Certificated nurses	As for other Registered or Certificated nurses (Certification or Registration)	
Midwife (enrolled or registered nurse)	Registered midwife with Higher Certificate; Certification or Registration limited to field of main experience	Maximum as for other Certificated or Registered nurses subject to remission in respect of midwife training	As for other Certificated or Registered nurses (Certification or Registration)	
Midwives other than registered or enrolled nurses	Registered midwife with Higher Certificate	As for new entrants, subject to remission	As for new entrants, subject to remission (Certification or Registration)	
RNT, HV Tutor, MTD, some DN Tutor	Lecturer in field of main knowledge	N/A	N/A	DN Tutors should be assimilated as lecturers or clinical tutors at the discretion of the statutory body
RCNT, some DN Tutor, CI in midwifery	Clinical tutor in field of main knowledge	N/A	N/A	
FWI, PWI, midwife with recognised teaching responsibilities	Dual clinical/teaching post	N/A	N/A	

APPENDIX I

RESEARCH PROJECTS AND METHODS

RESEARCH PLANNING

1. From the start of our enquiries we decided as a Committee:
 - (a) to set up a small research team of our own to initiate and supervise necessary research enquiries and to produce research papers;
 - (b) to commission a number of research surveys from other bodies.
2. The following original research projects were undertaken for the Committee:
 - (a) a postal survey followed by an interview survey to collect the opinions of nurses and midwives on various aspects of their work and some other information (see paragraph 5 below);
 - (b) a survey of qualified nurses and midwives not currently employed by the National Health Service as nurses and midwives;
 - (c) a survey of expenditure on nurse recruitment;
 - (d) a survey of the opinions and experience of overseas nurses (this survey was carried out with the assistance of the Committee but was not directly commissioned by it);
 - (e) a survey of current training arrangements for nursing auxiliaries and nursing assistants;
 - (f) a survey of non-statutory post-basic clinical nursing courses.

In addition we received some interim reports of DHSS-sponsored on-going research as, for example, a national study¹ of the enrolled nurse in the local authority nursing services carried out by the Queen's Institute of District Nursing.

THE OPINION SURVEYS

3. We were interested in collecting the opinions of nurses and midwives on their motives for entering the profession, the nature of their work and their likely career prospects. We also wanted some further factual information. Our object was to have at our disposal an up-to-date survey of the profession more comprehensive than any previously undertaken.

4. In the autumn of 1970, therefore, we commissioned Social and Community Planning Research to carry out an enquiry designed in three parts:

- (a) a postal survey of a representative sample of nurses and midwives;
- (b) a pilot depth survey carried out by interviewing a small cross section of nurses and midwives to determine questionnaire content and reliability;
- (c) a personal interview survey from a sub-sample of nurses and midwives replying to the postal survey.

(a) *The postal survey*

5. The main purpose of the postal survey was to collect factual information about nurses and midwives in hospitals and in the service of local authorities

¹ See list of references, no. 51.

which would augment that already available from official statistical records and previous research. The enquiry included the following topics:

- characteristics and family background of nurses and midwives currently working in different types of post;
- training;
- hours of work;
- past career, both nursing and non-nursing;
- extent of satisfaction with nursing as a career;
- views on future career prospects;
- levels of individual responsibility;
- factors affecting morale.

6. Questions dealing with attitudes towards nursing and midwifery could not be covered in great depth in a self-administered questionnaire, but the large sample used provided an opportunity for comparing the outlook of different groups in the profession in general terms.

Sampling technique

7. Two different questionnaires were used, one for hospital nurses and one for local authority nurses. The two questionnaires were generally similar but contained some questions specific to community or hospital nurses. A copy of the hospitals questionnaire is printed at the end of this Appendix. The hospitals and local authority samples were completely independent. For the hospitals, the 1970 edition of the *Hospitals Year Book* was used to provide a complete list of Hospital Management Committees, Boards of Governors and Boards of Management. The list of hospital groups was stratified by first separating (in England and Wales only) groups with medical teaching responsibilities from others, then by separating off Regional Hospital Boards. Within each Board, the Hospital Management Committees or Boards of Management were listed in descending order of average hospital size. This index was calculated as the total number of beds within a hospital group divided by the total number of hospitals.

8. In determining the sample, each of the groups of teaching hospitals in England and Wales for purposes of weighting was deemed to consist of two groups, i.e., it was given double its proper chance of selection. This was done in order to increase the number of such groups represented in the sampling, in view of the small number of groups in this category. This procedure did not lead to a bias in the overall sample since a correction was built into the second stage selection.

9. From the list of hospital groups, one hundred were selected at random with equal probability for inclusion in the sample. These groups then provided lists of their nursing and midwifery staff. From these lists a one-in-six constant interval sample of individual nurses and midwives was selected. But in the teaching hospitals in England and Wales, which had double their proper representation at the first stage, the interval was halved to one in twelve in order to correct the balance. The complete one-in-six sample produced too many names and some were deleted at random, giving a final sample of 10,407 names.

10. Exactly similar procedures were used to select the independent sample of community nurses and midwives. A list of local health authorities (i.e., county

councils and county boroughs) was stratified by listing the boroughs following the counties within which they lie, rather than listing boroughs and counties separately. From this list, forty-five authorities were selected at random. These then supplied lists of nursing and midwifery staff employed by them. From these lists one in two were selected for inclusion in the sample, and since this produced too many names, some were deleted at random to reduce the number to 2,483.

Response

11. The content, wording and layout of the questionnaire were all carefully considered in the light of the fact that nurses and midwives with a wide range of educational backgrounds would be completing it without assistance from an interviewer. Two types of pilot test were carried out. In the first type a pilot questionnaire was mailed to 120 hospital nurses and midwives and sixty community nurses and midwives using exactly the same methods that were planned for the main survey. The objects were to check the mechanics of the survey and to check that the methods would achieve a high response. In the event response rates of eighty and ninety per cent were achieved respectively at this pilot stage. The second pilot test was designed to show whether the questions were well conceived. Trained interviewers visited sixteen hospital nurses and midwives and six local authority nurses and midwives. The interviewer gave a questionnaire to the respondent, did not help her, but asked her to fill it up in front of her, explaining why she did everything she did. This cleared up some errors in the wording of the questions, but showed that the framework as a whole was satisfactory.

12. Each selected nurse or midwife was sent an envelope containing a questionnaire, a personal letter from the Chairman of the Committee asking for cooperation, and a stamped addressed return envelope. Two reminders were sent out. The speed of response was rather slower than is usually the case with surveys. But this was perhaps to be expected in view of the length of the questionnaire and suggests that nurses and midwives waited for an opportunity to devote care and time to its completion.

13. The final net response rates (which discount non-response where this was due to movement of staff and thereafter was beyond the control of the nurses and midwives or the researchers) were seventy-nine per cent for hospital nurses and midwives and eighty-seven per cent for community nurses and midwives. The achieved response was generally fairly even by grade, an important point to the Committee, since if any grades had been much more or less conscientious than others in replying, this would have biased the results. The relations between the sample and the population, by grade, sex, working status and hospital type are shown in Table A.1 on page 223.

14. In only one case does the achieved sample differ from the expected by more than one percentage point. There is some bias against auxiliaries and assistants, some of whom have had most difficulty in replying to the questionnaire. Their gross response rate appears to have been nearer sixty-three per cent than the seventy-three per cent average.

(b) The depth interview survey

15. The purpose of this study was to obtain qualitative insight into the problems and satisfactions of the profession from the point of view of the nurse or

TABLE A.1

**DISTRIBUTION OF RESPONSE TO POSTAL SURVEY
AND COMPARISON WITH POPULATION OF NURSES
AND MIDWIVES IN EMPLOYMENT IN GREAT BRITAIN***

<i>Grade</i>	<i>Sample</i>	<i>Population</i>
Senior nurse†	5	4
Sister/Staff nurse	28	27
Midwife‡	6	6
Student§	16	16
Enrolled nurse||	16	14
Pupil	6	7
Assistant/Auxiliary	21	25
Sex:		
Male	11	10
Female	89	90
Working status:		
Full-time	67	66
Part-time	33	34
Hospital type:		
Acute/other	81	80
Psychiatric	19	20

* Percentages may not sum to 100 due to rounding.

† Nurses who classified themselves above the rank of ward or departmental sister.

‡ Including student and pupil midwives.

§ Including post-registration students.

|| Including senior enrolled nurses.

midwife, and to provide a background for the design of the questionnaire used in the personal interview survey.

16. The study was based on interviews on which no formal questionnaire was used but interviewers were provided with a detailed guide of topics to be covered. The nurses and midwives were interviewed individually and in private, and were encouraged to talk freely about all aspects of their work and training. The interview was recorded in full, either on tape or in shorthand, and later transcribed for full analysis. The guide of topics given to the interviewers as a basis for discussion covered the following major subject areas:

- reasons for becoming a nurse or midwife;
- training undertaken;
- present position and role;
- breaks from nursing or midwifery;
- future plans.

17. Interviews were carried out in eight hospitals and two local authorities. Since the results were to be treated only qualitatively no attempt was made to achieve a statistically representative sample of nurses and midwives. The aim was to provide a reasonable cross-section of all types of nurses and midwives in order to assess the range of attitudes that exists within the nursing and midwifery profession. This range of attitudes could then be examined quantitatively in the personal interview survey.

18. Interviews were carried out at:

the branches of a large London teaching hospital;
a mental handicap hospital in the South of England;
a small geriatric hospital in the West of England;
an acute hospital in Wales;
a mental hospital in the North of England;
a general hospital in the North East of England;
a psychiatric hospital in Scotland;
a general hospital in Scotland;
a county borough health authority in England;
a county council health authority in Scotland.

19. Nurses and midwives interviewed were of the following grades:

five nurses in administrative or tutorial grades;
six sisters or staff nurses;
five midwives, ranging in grade from a departmental midwifery sister to a pupil midwife;
seven student nurses;
six state enrolled nurses;
five pupil nurses;
six nursing auxiliaries or assistants;
six local authority nurses.

Of the forty-one nurses interviewed, eleven were men.

20. Because of the informal structure of the interviews, and because the sample was small and selected purposively, the only conclusions which could be drawn from the study related to the range of attitudes held in the profession. The survey achieved its major purpose, that of providing the necessary background for the personal interview survey.

(c) The personal interview survey

21. It was decided to select nurses and midwives for the second survey from among those who had already completed a questionnaire in the postal survey so that it would be possible to relate the sets of answers to each other. Forty hospital authorities and eighteen local authorities were chosen as the sampling frame for the interview stage.

Sampling technique

22. For the hospital sample a total of 1,505 hospital nurses and midwives were then selected from respondents to the postal survey within the forty hospital authorities. Because of the need to get a sufficiently large number of interviews in each grade a structured, rather than a simple, random sample by grade was selected, with consequent weighting at the analysis stage. The number of nurses and midwives selected at random from each of the grade categories was as follows:

TABLE A.2

**STRUCTURE OF THE SAMPLE USED
IN THE INTERVIEW SURVEY**

Senior nurse*	190
Sister/Staff nurse	190
Midwife†	125
Enrolled nurses‡	250
Student§	250
Pupil	250
Auxiliary/Assistant	250

* Nurses and midwives who classified themselves above the rank of ward or departmental sister.

† Including student and pupil midwives.

‡ Including senior enrolled nurses.

§ Including post-registration students.

23. In analysis the results were weighted to correct for the fact that as the sampling of each grade of hospital nurse and midwife was undertaken independently, some groups were over- and some under-represented in the total sample. The weighting was done by taking each of the seven groups of hospital nurses and midwives for which there were separate samples and weighting up to the numbers achieved in the postal survey which constituted very nearly a true cross-section of the population. Each group was multiplied by a ratio:

$$W_t = \frac{\text{Numbers achieved in postal sample}}{\text{Numbers achieved in interview sample}}$$

24. The weights actually used are tabulated below. The second column shows the ratio between that weight and the lowest weight so that the spread of weighting factors can be assessed.

TABLE A.3

WEIGHTING APPLIED TO THE INTERVIEW SURVEY RESULTS

<i>Grade</i>	<i>Weight</i>	<i>Ratio to lowest</i>
Senior nurse*	2.844	1.3
Sister/Staff nurse	12.267	5.4
Enrolled nurse†	6.048	2.7
Student‡	5.551	2.5
Pupil	2.252	1.0
Midwife§	5.170	2.3
Auxiliary/Assistant	8.071	3.6

* Nurses and midwives who classified themselves above the rank of ward or departmental sister.

† Including senior enrolled nurses.

‡ Including post-registration students.

§ Including student and pupil midwives.

It should be noted that these weights were applied on the basis of the grade recorded in the postal questionnaire which was the source for the selection procedure. In the analysis of the interview survey, the breakdown by grade was according to the interview data since some nurses and midwives would have changed grades in the meantime.

25. The selection of local authority nurses and midwives was made from those replying in the postal survey. From the forty-five local authorities involved, fifteen were selected at random in order to concentrate the interviews into quotas of suitable size. As this was found to involve bias towards the three English county authorities, a further three counties were included and the proportion of nurses and midwives in each halved to compensate. The procedure was thus self-correcting. Within these authorities 410 nurses and midwives were selected at random for inclusion in the sample.

26. No weighting was applied to the local authority data.

The questionnaires

27. Three separate questionnaires were used, one for hospital nursing and midwifery staff, a modified version of the same questionnaire for senior staff above the level of ward sister or charge nurse in hospitals and one for local authority staff. The main hospitals questionnaire is printed at the end of this Appendix. The main areas covered were as follows:

- recruitment to hospital service; reasons for choice of first hospital;
- location of first hospital in relation to residence; source of information about the hospital and numbers of applications made to different hospitals;
- method of travel to work; costs of travel to work;
- attitudes to adequacy of training on and off the wards; views on student status;
- attitudes to pay, hours and shift systems; main complaints; views on where the responsibility lies for improvements;
- views on career prospects;
- views on their role as a nurse or midwife and on patient and task allocation;
- relationships between senior and junior nurses and midwives;
- attitudes to local authority nursing and midwifery;
- attitudes on return to work and to family responsibilities;
- social background.

28. The questionnaire for senior staff in hospitals was generally similar. It included some additional questions about whether senior nurses and midwives were satisfied with their influence over various items of nursing and midwifery and hospital policy; and whether they felt these policies to be satisfactory. The policy issues included standardisation of nursing and midwifery procedures, allocation of staff between wards, systems of patient records, admissions and discharges, coordination between teaching and staffing and communication with sisters and staff nurses and midwives.

29. The local authority questionnaire covered many of the same issues as the hospital questionnaire. It also looked at the attitudes of community nurses and midwives towards the present divisions in the profession and to relationships with hospital nurses and midwives and general practitioners.

30. The questionnaires were piloted in a series of interviews. The interviews proper were carried out during May and June of 1971. Nursing Officers and staff in many cases went to very considerable trouble to arrange the schedule of interviews. The interviews took place in private rooms, out of earshot of other nurses and midwives. The net response rates were good; eighty-seven per cent for

hospital nursing and midwifery staff (1,282 interviews) and ninety per cent for community nursing and midwifery staff (373 interviews). The net response rates for the double surveys, allowing for the non-response in the postal survey, were sixty-nine per cent for hospital nursing and midwifery staff and seventy-eight per cent for local authority staff.

A SURVEY OF RESERVES OF NURSES

31. As a further part of our enquiry, we thought it indispensable to collect information not only about nurses and midwives currently employed in the profession but about nurses and midwives currently withdrawn from the labour force, or working outside nursing and midwifery. We commissioned a fourth survey, therefore, which was carried out for us by the Office of Population Censuses and Surveys.

32. The 1971 Census included questions which dealt with qualifications obtained since the age of eighteen, with current employment status and with the number of hours worked. Based on these questions OPCS was able to select a sample of 1,134 people living in Great Britain who had nursing or midwifery qualifications but were not, at the time of the census, employed by the National Health Service as nurses or midwives.

33. The sample was arrived at by first selecting at random one hundred census districts from the 2,384 in Great Britain and six enumeration districts from each selected census district. Second, within each of these six hundred enumeration districts all people with nursing or midwifery qualifications who were not working in the National Health Service were included in the sample. Thus, the 1,078 women and fifty-six men in our sample of areas selected at random represent an estimated two hundred and twenty-eight thousand under seventy years of age with nursing or midwifery qualifications but not working in the National Health Service in all of England and Wales and Scotland. All men and all women born before 1919 were then excluded from the sample, giving a final sample of 709 women. These 709 women were approached for a personal interview by trained interviewers from OPCS. The response was as follows:

TABLE A.4
RESPONSE TO THE SURVEY OF RESERVES OF NURSES

		<i>Per cent</i>
1. Women who appeared from their census schedules to be eligible to be interviewed	709	
Of these:		
2. Number later proved to be ineligible	24	3
3. Number who had moved and could not be traced (eligibility not established)	21	3
4. Number who could not be contacted, but were definitely eligible*	12	2
5. Number who refused to be interviewed, but were definitely eligible	24	3
6. Number of interviews obtained	628	89

* Category 4 includes some women who had emigrated and some who were ill, etc., but whose eligibility was satisfactorily established.

34. If the definitely ineligible group in category 2 is excluded from category 1, the overall response rate (i.e., the proportion of nurses and midwives who were interviewed) becomes ninety-one per cent.

35. The interviews were conducted during the period 1 August to 24 September 1971. The main topics covered were:

educational background; training experience and career in nursing and midwifery;

experience with refresher courses and attempts to return since leaving nursing or midwifery;

extent of satisfaction with nursing and midwifery;

present employment and conditions; hours, extent of evening and weekend work; level of earnings; the journey to work;

family responsibilities and background; social and economic status;

attitudes to different types of nursing and midwifery, e.g., general or psychiatric nursing: hospital or community work;

likelihood of return; opinions about refresher courses, hours of work and shift systems; willingness to do night and weekend work;

contacts with nursing and midwifery and with the National Health Service;

attitudes to women working; husband's attitudes to work outside the home;

main disincentives to return; changes which would help return.

36. The general response to the questionnaire was good. The survey provided data which could be used in the calculation of "participation rates"¹ for nurses and midwives and a figure for the size of the reserve of trained nurses and midwives not currently nursing or practising midwifery who could be attracted back into the profession. It also provided information on the opinions and attitudes to nursing and midwifery of nurses and midwives who were not currently in the profession.

37. Two decisions about methodology had to be made at an early stage. First, what should be included in the list of acceptable nursing and midwifery qualifications? Second, which people should be taken as working currently within the National Health Service and therefore ineligible?

38. A list of acceptable nursing and midwifery qualifications is agreed between the Department of Health and Social Security and the Office of Population Censuses and Surveys before the processing of each population census. The list for the 1971 Census was used as the basis of selection for this survey. Although this list contained approximately forty acceptable qualifications, in fact almost all individuals included in the sample possessed one or more of the qualifications SRN, RGN, SEN, RSCN, RMN, RNMS, RNMD, RFN or SCM, though they often possessed others of the forty qualifications in addition.

39. The survey of nurses and midwives employed within the National Health Service included a sample of nurses and midwives employed at all levels in National Health Service hospitals and a sample of community nurses and midwives; i.e., district nurses, health visitors, domiciliary midwives and other nurses and midwives in supervisory posts in this field. The OPCS survey excluded nurses and midwives in both these categories, but included all other qualified nurses and midwives, viz. those not working at all, those working in a job with no connections with nursing or midwifery and those working as nurses or midwives not in National Health Service hospitals or as community nurses or midwives, but elsewhere e.g., school nurses, factory nurses, private or agency nurses and midwives etc.

¹ Percentage number of the population defined as currently in employment in the National Health Service as a nurse or midwife.

40. All qualified nurses and midwives, with one exception, were eligible either for the SCPR study or for the OPCS study but not for both. The exception was nurses and midwives living in non-National Health Service institutions. Because of the organisation of the census operation OPCS included in its sample only people living in private households. As a result any nurses or midwives living in boarding schools, some Forces establishments, hospitals such as Broadmoor, private nursing homes etc. would have been automatically excluded, although nurses and midwives working in such establishments but living out would have been included.

41. The survey of nurses and midwives not currently in employment as nurses and midwives in the National Health Service was the first such systematic research study undertaken, to our knowledge, in Britain. It thus provided a considerable volume of information not previously available and was of major interest to the Committee.

A SURVEY OF EXPENDITURE ON NURSE RECRUITMENT

42. We also undertook a survey of expenditure on nurse and midwife recruitment and recruitment activities at local level. This survey was carried out by our research staff on the basis of a questionnaire drafted by the Committee.

43. The questionnaire was sent to all hospital authorities (Hospital Management Committees, Boards of Governors and Boards of Management) in Great Britain and was in two parts. The first part covered the six months from 1 October 1970 to 1 April 1971 and the second covered the six months from 1 April 1971 to 30 September 1971. Thus, while information for a full year was obtained, the Committee was able to consider evidence relating to six months at a reasonably early stage in its deliberations.

44. The information asked for was:

- (a) total expenditure on advertising in the three previous financial years, ending 1969/70;
- (b) expenditure on advertising in the time period on—
 - (i) all types of staff;
 - (ii) nursing and midwifery staff, in total and sub-divided by various categories of staff;
- (c) other recruitment expenditure related to nursing and midwifery staff;
- (d) numbers of nursing and midwifery staff newly appointed during the period;
- (e) types of recruitment activity undertaken and personnel engaged in recruitment activities.

45. The response to the survey was slow, with the results that a final report on the survey could not be prepared until a fairly late stage in the life of the Committee. The eventual national response rate was eighty-four per cent to the first half of the survey and seventy per cent to the second at the time when a final report was prepared. There was such a measure of regional variation in response, however, that estimates of regional variation in expenditure drawn from the survey had to be treated with caution. The main value of the survey lay in the national picture that emerged rather than in the presentation of detailed material suitable for an analysis and interpretation of regional variation.

46. The survey showed that while there was a continuing increase in annual expenditure on nursing and midwifery recruitment, it is difficult or impossible to sub-divide expenditure into expenditures on the recruitment of particular groups of nursing or midwifery staff. A considerable proportion of hospital authorities tended to classify all their nurse and midwife advertising expenditure as "general expenditure" and were unable to sub-divide their general nursing and midwifery advertising expenditure into expenditure on different grades (qualified staff, students and pupils and other nursing staff).

47. Despite these problems a number of estimating and "grossing up" procedures were used in an attempt to derive useful conclusions from the survey. It was possible to arrive at figures for total recruitment expenditure for the "share" of "local" advertising expenditure on the recruitment of nurses and midwives in total advertising expenditure on recruitment (estimated to be approximately forty per cent on a national basis), and for the rate of change of expenditure over the four years on which information was collected. Above all, valuable information was acquired on the type of recruitment activity undertaken by senior nursing and midwifery staff in hospitals.

SURVEY OF OVERSEAS NURSES

48. A further piece of important research was suggested to us from outside, although it fitted naturally into our own enquiries. The United Kingdom Council for Overseas Student Affairs (UKCOSA) has been concerned for some time about the position of nurses and midwives from overseas who are studying in Britain, especially those from developing countries. It asked Political and Economic Planning (PEP) which has for many years carried out a number of studies relevant to this area, to undertake a research project on this subject and to put its report at the disposal of our Committee.

49. The postal survey we were carrying out provided some basic data on the numbers and distribution of overseas nurses and midwives in Britain, but it was not possible to cover problems specific to overseas nurses and midwives in a questionnaire designed to be answered by all nurses and midwives. Cooperation between SCPR and Mr. Michael Thomas, Senior Research Officer of PEP, was established, and a specially designed enquiry was launched (with the agreement of OPCS), in order to investigate the following topics:

- motivations and expectations of nurses and midwives from developing countries in coming to Britain;
- reasons for their choice of hospital and their course of training;
- experience of the selection procedure for the course;
- language problems;
- early experience on arrival in Britain;
- awareness of and reaction to British immigration provisions applicable to them;
- general adaptation and morale;
- views on the courses they were following, or had followed, and their plans on completion of the courses;
- personal details.

50. The first stage of the research consisted of twenty-one depth interviews with nurses who had come to Britain to train from one of the developing countries.

Skilled interviewers carried out the fieldwork in four hospitals (one London teaching hospital, two general hospitals and one mental hospital). They used a guide of topics to be covered, and the interviews took the form of free conversations, which were written up as closely as possible in the informants' own words.

51. The depth interviews gave a considerable amount of insight into the types of problem experienced by nurses and midwives from developing countries. They indicated that difficulties mainly centred around choosing a hospital and a course and around the early weeks in the country. Accordingly, these topics were given special attention in the questionnaire. The depth interviews also showed that interviewers and informants could have difficulty in understanding each other.

52. The second stage consisted of 259 interviews using a structured questionnaire based on the information obtained from the depth interviews and covering the topics discussed earlier. Although the questionnaire consisted of a series of specific questions, there were questions on the list to which the answers were recorded in detail in the informants' own words and not forced into preconceived answer categories. Because of language problems, interviewers were given more leeway than is usual to reword and explain questions. Interviews lasted about one hour. Fieldwork took place during August and September 1971.

53. Since the sample to be interviewed was small, it was structured to ensure certain numbers of informants in different categories rather than to be a representative cross-section of nurses and midwives from overseas. Certain other constraints also prevented a completely random selection of nurses and midwives:

- (a) the research workers were asked to avoid interviewing a second time, and nurses and midwives who had already been included in the interview phase of the research for the Committee on Nursing were excluded from the selection procedure;
- (b) the names for the postal survey had been originally collected in December 1970. All informants selected through this frame would have been in Britain, therefore, for at least nine months at the time of fieldwork. There would thus be no really new entrants in the sample. Some system of making good this deficiency was required.

54. Among the returns to the postal survey, there were 581 nurses and midwives born in a developing country, whose father was also born in a developing country, and who came to Britain after the age of sixteen. The assumption could be made that the majority of these had come to Britain specifically to train as nurses (though this was not asked about). These were defined as "overseas nurses".¹ These nurses and midwives were listed by computer under their hospital groups.

55. It was also intended to include as a control group a small group of nurses and midwives from Eire. The 341 nurses and midwives from Eire were similarly listed.

56. Those hospital groups which contained at least ten nurses and midwives from underdeveloped countries or Eire who had replied to the postal survey were selected for inclusion. The sample thus tends to be biased in the direction of

¹ Developing countries were taken as West Indies, South America, Africa and Mauritius (excluding South Africa), Malaysia, India, Pakistan and Middle East states not in Africa (excluding Israel) and South East Asia (including the Philippines but excluding Australia and New Zealand).

the larger hospital groups and those which recruit a relatively high proportion of "overseas nurses and midwives".

57. A total of 259 names were selected at random from those available to provide the following numbers by grade:

TABLE A.5

NUMBERS BY CATEGORY* IN THE SURVEY OF OVERSEAS
NURSES

	<i>"Overseas nurses and midwives"</i>	<i>Nurses and midwives from Eire</i>
Staff nurses and midwives	35	8
Student nurses†	50	15
Enrolled nurses‡	35	8
Pupils	50	15
Auxiliaries/Assistants	35	8
Total	205	54

* In some grades all the nurses and midwives from developing countries available in the selected hospital groups were included.

† Including post-registration students.

‡ Including senior enrolled nurses.

Since the emphasis of the study was on training, senior nurses and midwives and ward sisters were not included unless a named nurse or midwife had been promoted since completing the postal survey.

58. If a named nurse or midwife had moved from the hospital, was away for longer than the interview period or refused to be interviewed, a substitute was taken from among those who had recently arrived in Britain. The object was to take nurses and midwives who had arrived since 1 December 1970, but there was not always one available. As far as possible the substitute was from the same part of the world as the named nurse or midwife and taking the same type of course. Staff nurses were replaced by student nurses and enrolled nurses by pupil nurses. In all, seventy substitutes were taken but only twenty-eight had arrived since 1 December 1970.

59. Further details of the sampling procedure were as follows. Eighteen hospital groups were covered in the sample. These were all those with a minimum of ten "overseas" or Irish nurses or midwives who had completed the postal questionnaire for the Committee on Nursing. They were spread throughout England and the regional distribution of "overseas nurses and midwives" in these groups did not differ markedly from that in the total sample of "overseas nurses and midwives" available from the postal survey. No group in Scotland or Wales contained sufficient "overseas nurses or midwives" for inclusion.

60. Letters explaining the purpose of the survey and asking for their co-operation were sent to the Group Secretary. One refused to allow interviewing to take place in his group. Since no other group was available with sufficient "overseas nurses and midwives" to make its inclusion an economic proposition, interviewers were asked to obtain an additional interview, preferably with a student nurse, in each hospital group. This change, together with the replacement of staff nurses who had moved by student nurses, accounts for the relatively large

proportion of the sample in the student nurse category (eighty-one), compared with the original number issued in the sample (fifty).

61. The sample interviewed was as follows:

TABLE A.6

SURVEY OF OVERSEAS NURSES RESPONSE

	<i>"Overseas nurses and midwives"</i>		<i>Nurses and midwives from Eire</i>
	<i>Number</i>	<i>Per cent*</i>	
Staff nurses and midwives	22	11	7
Enrolled nurses†	30	15	17
Students‡	81	39	9
Pupils	41	20	8
Auxiliaries/Assistants	30	15	5
Not classified	2	1	—
	206	101	46

* Percentage distribution does not sum to 100 due to rounding.

† Including senior enrolled nurses.

‡ Including post-registration students.

A complication in analysing the questions about choice of hospital and arrival in Britain was that all the named nurses and midwives had come to Britain specifically to enter nursing or midwifery: sixty-five of those from developing countries and six of those from Eire immigrated for other reasons. These were mainly in the auxiliary/assistant (twenty-three), pupil (fourteen) and enrolled nurse (thirteen) grades.

62. The type of sampling procedure used and the small size of the sample place this survey into the category of "qualitative" rather than "quantitative" research. Yet it gives a broad picture of the experience and attitudes of nurses and midwives from developing countries training in Britain and of their problems.

A SURVEY OF CURRENT TRAINING ARRANGEMENTS FOR NURSING AUXILIARIES AND NURSING ASSISTANTS

63. This useful enquiry relating to nursing auxiliaries and assistants employed in National Health Service hospitals and ancillary staff employed on nursing duties by local authorities was carried out on behalf of the Committee by our own research staff on the basis of questionnaires drafted by the Committee. The object of the enquiry was to produce a comprehensive picture of educational and training functions in hospitals and local authorities. One questionnaire was sent to all hospital authorities in Britain; a similar questionnaire was sent to all local health authorities and delegated health authorities in Britain. Completed questionnaires were returned by eighty per cent of hospital authorities and ninety-seven per cent of local authorities.

64. The information asked for was:

- details of any orientation courses and/or training courses provided;
- total length of training provided;
- the proportion of auxiliaries, assistants or ancillary staff attending such courses;

details of which department was responsible for orientation and/or training courses;
the form of any training or instruction provided;
details of procedures taught by way of practical instruction in the wards or departments;
numbers who have subsequently started training for the roll or register.

65. Details of 594 training courses for nursing auxiliaries in England, Scotland and Wales were obtained. The survey provided, for the first time, a clear indication of the work that nursing auxiliaries are trained to do and the extent to which this training is carried out on the job.

66. Details of 218 training courses for nursing assistants in England, Scotland and Wales were obtained. As was to be expected the replies indicated that the syllabus recommended in HM (55) 49¹ had been widely implemented.

67. Details of 147 training courses for ancillary staff (nursing duties) in England, Scotland and Wales were obtained. At the time the questionnaire was completed, only sixty per cent of local authorities employed ancillary staff on nursing duties.

A SURVEY OF NON-STATUTORY POST-BASIC CLINICAL NURSING COURSES

68. A survey of non-statutory post-basic clinical nursing courses was also carried out on behalf of the Committee by our own research staff. The Committee drafted a questionnaire in consultation with the Joint Board of Clinical Nursing Studies (England and Wales), and to avoid two approaches being made for the same information the details of post-basic courses in hospitals in England and Wales was passed to the Joint Board. The questionnaire was sent to all hospital authorities in Great Britain and a response rate of eighty-eight per cent was achieved.

69. The information asked for was:

type of course and qualification required;

duration and frequency of course;

number and source of students on the course;

details of learning and study time;

examination procedure;

the name of the person or department responsible for the course and details of lecturers and/or teachers;

financial arrangements.

70. Details of 401 post-basic courses in twenty-four different categories were obtained. From the replies it was possible to produce tables showing the variety and frequency of courses and their geographical distribution and to compare details of similar courses in different parts of Great Britain.

OTHER RESEARCH PROJECTS CONSIDERED BUT NOT CARRIED OUT

71. The Committee also gave consideration to three other possible areas of research:

- (a) a survey of nurse and midwife staffing, using dependency criteria, to establish nursing and midwifery requirements. Such a survey, difficult to

¹ See list of references, no. 76.

carry out, might have permitted us to produce a quantitative estimate of the need for nurses and midwives;

- (b) the construction of a statistical model to assist in assessing current shortages and in forecasting future levels of staffing. Such a model would have served a similar purpose to that of the projections made by the Report of the Royal Commission on Medical Education;
- (c) a survey addressed to employers of employment practices covering matters such as wastage, sickness and absenteeism which do not emerge from a survey answered by the nurses and midwives themselves. The following general topics could have been illustrated by such a survey:
 - the derivation and level of establishment figures;
 - nursing stability and wastage;
 - indicators of nursing shortage—such as bed closures, (although nursing shortage may not be the only cause of such closures);
 - indicators of market pressures on the supply of labour for nursing and midwifery such as numbers of applications per vacancy for detailed occupations;
 - equipment levels as indicators of technological advance;
 - policies concerning part-timers;
 - policies on shift systems;
 - policies relating to other conditions of work.

REASONING BEHIND OUR RESEARCH PROGRAMME

72. While we would have carried out the third of these studies had we had the time and the resources, we decided at a preliminary stage in our work not to seek to go ahead with the first and second. The major reason for our decision was that given the current stage of knowledge they are simply not feasible. We hope that these will be the type of projects the manpower units, whose establishment is recommended in our Report will examine, but they would be major research projects involving some years of research. Their time-scale alone ruled them out of consideration as far as the Committee was concerned.

73. An aggregate measure of shortage of nurses and midwives appears to have attractions. Yet conceptually it poses many difficulties. Staff in nearly every hospital feel themselves to be short of nurses, and anxiety about shortage is not related to levels of staffing. Subjective views are thus likely to be a poor guide. Nor is it easy to measure “shortage” without a clear definition of “role” and of the “standards of care” to be achieved.

74. The main attempts until now to measure “shortage” have been in the DHSS Deployment Study,¹ the Aberdeen Study,² dependency studies³ such as those pioneered by Dr. A. Barr of the Oxford Regional Hospital Board, and in locally set figures for establishments.

75. The DHSS study is based on deviations from average staffing figures in acute hospitals. Its main weaknesses are that it does not incorporate explicit standards in quality of care, that professional judgment is not brought into play and that it involves the application of national ratios to diverse local situations.

¹ See list of references, no. 27.

² See list of references, nos. 122 & 123.

³ See list of references, no. 98.

While some attempt has been made to build in allowances for local variations, the results do not command general confidence. Moreover, even if local variations were fully allowed for, the study could only measure relative shortage.

76. The Aberdeen study is more promising in that it both brings professional judgment into play in the setting of standards and that it incorporates data on dependency. Dependency studies of the kind pioneered by Dr. Barr usefully build up dependency data and go on to use staffing norms to determine nursing requirements.

77. We believe that it is valuable locally to approach problems of shortage in this way with a view to making the most effective use of manpower and other resources and that in local settings (with different recruitment situations) such measures of shortage need to be considered along with other evidence on standards of care. This evidence would include such questions as mix of staff and the extent of coverage by trained nurses at night.

78. At the same time, we do not believe that it is possible at the present time to pass practicably (in a changing situation) from local to national research studies (quantitatively based) which will help policy makers. Nursing needs are not consistently related to dependency levels and there are difficulties in allowing for variation by specialty. Barr and Moores in an important unpublished recent paper discussing these methods stress that "there is no single nurse staffing ratio which is generally applicable throughout the hospital service".

SUGGESTIONS FOR THE FUTURE

79. Given that nursing and midwifery have to concentrate on making a more effective use of manpower and to identify carefully defined situations of shortage, it follows that much more needs to be known not only about numbers in the nursing and midwifery labour force but also about behaviour. We need to have more systematic information about the internal labour market in nursing and midwifery, recruitment difficulties for particular grades or types of skill, and not least, the pattern of turnover. At present we have a abundance of "moment of time" data with the nursing and midwifery labour force being subject to a half-yearly census of numbers, but we have little information on movement between different areas of the National Health Service and into and out of the National Health Service.

80. The Health Departments and central training bodies could cooperate to produce more detailed "flow" information. With the establishment of manpower and personnel departments at Area level the information should be more easily collected, possibly on the basis of a single annual return of a more comprehensive nature than anything undertaken at present. The major priority is that manpower and personnel departments should keep information on where recruits come from (to be asked at initial interview) and where they leave for (to be asked at terminal interview if leaver will cooperate). We are aware of the difficulty of getting reliable information from leavers, but on balance we consider that it is well worth the effort.

81. Detailed information could then be collated on:

(a) entrants to nurse training: by sex, age, education and previous employment. This would provide information on how far nursing was succeeding in tapping the various recruitable pools. It would show how many recruits came directly from school and how far nursing was succeeding in persuading mature women to take up nurse training after bringing up their families;

- (b) re-entrants (qualified nurses and midwives): by sex, age and previous employment. This would provide vital information on the success of nursing and midwifery in attracting married women to return to the profession after bringing up their families;
- (c) wastage of those in training and of qualified nurses and midwives: percentage stability and wastage rates. Wastage numbers showing destination (e.g., other National Health Service employment, withdrawal from labour force, retirement), collected on a national scale would give a comprehensive picture of stability and movement within nursing and midwifery and into and out of nursing and midwifery;
- (d) stability and wastage of nursing assistants and auxiliaries: giving destination of leavers as above.

Such statistics would be helpful in relation to all policy discussion of staff "mix" and of quality of nursing and midwifery care.

82. We already have information on average levels of wastage, but we know too little about the range of variation between different hospitals. Such a regular survey of wastage and stability would show which hospitals had very high wastage rates—and would make remedial action possible.

83. Information on hiring by employers could also be part of this annual exercise. Information should always be available on the numbers of applications in relation to vacancies for defined grades.

OTHER RESEARCH

84. In carrying out our own researches and in identifying what we regard as some of the main points of national interest in future manpower research we have noted the past and present patterns of research activity on a broader front and areas where further research will in our view be useful. We have had the valuable help in this context of the Health Departments.

85. The 1940s saw the return, after a gap of nearly half a century, of the application of research to the examination of nursing and midwifery problems. The lead back was given by research workers from disciplines other than nursing and midwifery, but within a decade nurses and midwives were beginning to join in the studies. Nursing and midwifery problems have continued to interest research workers from a wide range of disciplines. Given the need to explore more fully the concept of "care" in a changing society, much of the research has strategic importance. One of the strengths of the current situation is the wealth of varied expertise attracted to nursing and midwifery studies. The volume of work has increased at an accelerating pace during the last ten years, although many areas are untouched, much of the work is fragmentary, and many of the conclusions are insufficiently advanced for immediate implementation.

86. For convenience, research in nursing and midwifery may be divided into three areas—service, practice and education. Certain studies overlap area boundaries (for example, studies of student recruitment and selection impinge on all three areas), but the division remains useful for descriptive purposes.

Nursing and midwifery service

87. Service studies relate to the provision of a nursing and midwifery service, to the physical and social environment in which the work is undertaken and to equipment, management, staffing and communication. Building studies started

in the late 1940s with the work of the hospital design research team set up by the Nuffield Provincial Hospitals Trust, which became the Nuffield Foundation Division of Architectural Studies.¹ The Department of Health and Social Security has taken the lead in the last twelve years with such activities as the Greenwich Hospital project and the Best Buy projects. Currently, the Harness hospitals project is based on the principle of standardised departmental design but still allows flexibility in assembly and use. Data systems developed from the earlier Cubith project have been used and are of general application.^{2, 3} In Scotland, we note the development of the "Falkirk Ward" design by a team of experts in the Scottish Home and Health Department. Management of the new style units has been the subject of operational research.⁴ Other management teams (for example, from Brunel University), are studying the implications of the implementation of the Salmon management structure.⁵ Individual aspects of management are also under review.

88. Nurses have been deeply concerned with the design of nursing equipment. Norton led the way in this with her studies of the care of old people,⁶ and later in work published as *By Accident or Design?*⁷. At the Royal College of Art nurses work with engineers and ergonomists on the design of such articles as beds, lockers, commodes and, at the Disabled Living Foundation, on aids for the disabled.

89. Staffing problems have presented a continuing challenge to research workers. Simple observation of what nurses do, as in the work of Goddard,⁸ has led to a classification of activities, an attempt to decide what is and what is not nursing work, and an effort to measure work loads. Experiments have been made as a result of such research, for example, in the use of waitress services,⁹ ward housekeepers,¹⁰ and topping up of linen supplies.¹¹ The "dependency" studies of Barr¹² and the conclusions of Barr and Moores¹³ have already been noted. A working party at the Hospital Centre is currently engaged, in cooperation with the Department of Health and Social Security, in trying to find the common basis of these studies which might be useful as a management tool and to identify the growing points for further research.

90. Finally, communication problems have proved as interesting to researchers in this field as they have done in others.

91. Communication with the patient has been the subject of several studies for example by Cartwright,¹⁴ Houghton¹⁵ and Raphael¹⁶ and Carstairs¹⁷. Ley¹⁸ is currently pursuing the subject further. Staff relationships and communication between staff has also attracted research workers, from Woodward¹⁹ (1950) to Revans (1972). The latest reports on this subject have just been published arising out of Revans' Hospital Internal Communications projects.^{20, 21}

¹ See list of references, no. 88.

² See list of references, no. 31.

³ See list of references, no. 26.

⁴ See list of references, no. 64.

⁵ See list of references, no. 7.

⁶ See list of references, no. 42.

⁷ See list of references, no. 87.

⁸ See list of references, no. 60.

⁹ See list of references, no. 111.

¹⁰ See list of references, no. 99.

¹¹ See list of references, no. 116.

¹² See list of references, no. 98.

¹³ See list of references, no. 4.

¹⁴ See list of references, no. 10.

¹⁵ See list of references, no. 52.

¹⁶ See list of references, no. 101.

¹⁷ See list of references, no. 9.

¹⁸ See list of references, no. 61.

¹⁹ See list of references, no. 121.

²⁰ See list of references, no. 102.

²¹ See list of references, no. 119.

Nursing and midwifery practice

92. A wide range of studies of the nurse/client relationship in all aspects of patient care and health promotion may be grouped under this heading.

93. The studies started with descriptions of what nurses do, usually employing work study techniques. Today interest centres on effectiveness of nursing practice. The work of nurses in hospital wards was studied by Goddard in 1953.¹ A recent descriptive study of the work of health visitors in London has come from the Greater London Council research unit,² and another by Clark is about to be published. Hunt M. showed health visitors' problems in role identification.³ Hobbs,⁴ is currently looking at factors which influence the participation of health visitors in group health education programmes. Other studies such as Morris's *Put Away*⁵ and Miller and Gwynne's *A Life Apart*⁶ not only describe nursing activity respectively in mental handicap hospitals and accommodation for the younger chronic sick but seek to interpret what is happening.

94. Hockey^{7, 8} in a series of studies of the work of local authority nurses threw light on many problems, and examined specific new developments like the attachment of local authority nursing staff to general practice. Such attachments have been considered also in a spate of mainly small scale descriptive studies, usefully summarised by Hawthorn in 1971.⁹ Some purpose-designed experimental situations were described and evaluated by Gilmore *et al.*,¹⁰ a study which is continuing. Ruckley and Maclean described experimental early discharge schemes,¹¹ as did Hockey.¹²

95. Particular aspects of nursing work have been or are being examined in detail. For example, at the Royal College of Nursing the performance of certain nursing tasks is being explored by a group of nurses.¹³ Care of the emotional needs of children in hospital is being studied by Stacey¹⁴ and others. Nurses in the mental illness field are partners in research into the use of operant conditioning techniques. Work in intensive care units was examined by Kilgour.¹⁵ Care of the elderly is now being widely studied, with studies ranging from the attitudes of nurses towards geriatric nursing to the care of the elderly in the community, the control of pressure sores, the control of pain in terminal cancer, the care of the dying in institutions and at home and the availability of care in the last year of people's lives.

Nursing and midwifery education

96. The group of studies considered under the heading of nursing education includes those relating to the provision of facilities for education, the organisation of education programmes and teaching methods. The studies may be carried out with reference to any stage of the education process from in-service training to degree courses, to work at basic, advanced or higher education levels.

97. Early studies concentrated on the recruitment, selection and wastage of student nurses. These were summarised by MacGuire in 1969.¹⁶ A major

¹ See list of references, no. 89.

² See list of references, no. 68.

³ See list of references, no. 54.

⁴ See list of references, no. 47.

⁵ See list of references, no. 80.

⁶ See list of references, no. 74.

⁷ See list of references, no. 48.

⁸ See list of references, no. 50.

⁹ See list of references, no. 45.

¹⁰ See list of references, no. 44.

¹¹ See list of references, no. 106.

¹² See list of references, no. 49.

¹³ See list of references, no. 70.

¹⁴ See list of references, no. 115.

¹⁵ See list of references, no. 58.

¹⁶ See list of references, no. 67.

study of male student and pupil nurses is currently in progress in the University of Hull.¹ A study by Banks 1969² looks at the allocation of student nurses.

98. Experimental training schemes have been in operation for some time. The first attempt to evaluate such a scheme was made by the Scottish Home and Health Department in 1963.³ Bryden conducted in 1969⁴ an assessment of an integrated course. An experimental scheme with a built-in evaluation device forms the subject of study by Pomeranz. A research unit at the General Nursing Council has been established specifically to study experimental schemes. Useful early reports relate, for example, to the graduate nurse population⁵ and characteristics of student nurse intakes.^{6,7} The first study to be published of an evaluation of first line management courses came from Davies⁸ in 1971. Studies are in progress of middle and senior management courses.

99. Tutors have been studied by Dutton⁹ who looked at factors affecting recruitment, by Wood¹⁰ who considered students' assessment of their tutors and by Lancaster who carried out an opinion study amongst tutors.¹¹

100. Teaching methods and learning have received less attention, and we believe that this is a field where research is necessary and where there should be the closest cooperation between nurses and those engaged in other branches of education. Marson¹² and Hector¹³ have both looked at programmed learning. Bendall¹⁴ has published a paper on the learning process in the case of student nurses and is continuing to examine the relationship between theoretical knowledge and its practical application. Hunt is looking at the relationship between what is taught in the classroom and what is practised in the wards.

101. In mentioning this selection of studies we are keenly aware that the list is by no means exhaustive and that many researchers from nursing and midwifery as well as other disciplines have been involved and are currently undertaking valuable studies of a variety of nursing and midwifery problems.

102. Particularly worthy of mention are the Nursing Research Fellowships financed from government research funds in England, Wales and Scotland. Fellows are attached to a variety of Universities, such as Manchester, Cardiff, Hull and Surrey, some of whom have already been referred to.

103. The University of Edinburgh with a full Department of Nursing Studies also has a Nursing Research Unit with financial support from the Scottish Home and Health Department. The Unit is currently investigating the staffing of nursing services at "socially unacceptable hours" with particular reference to the deployment of part-time nursing staff.

SUMMARY

104. This Appendix has set out details of how and why we embarked as a Committee on particular pieces of research, and how and why we rejected others. It has briefly described the methods employed. Most of the conclusions reached have been incorporated in the main text of our Report. The need for continuing research by the Central Departments, within the profession, by health authorities, educational bodies and others is stressed and in the main text of our Report we have explained in more detail how we think such research can and must be encouraged.

¹ See list of references, no. 6.

² See list of references, no. 3.

³ See list of references, no. 110.

⁴ See list of references, no. 8.

⁵ See list of references, no. 66.

⁶ See list of references, no. 112.

⁷ See list of references, no. 113.

⁸ See list of references, no. 21.

⁹ See list of references, no. 41.

¹⁰ See list of references, no. 120.

¹¹ See list of references, no. 59.

¹² See list of references, no. 69.

¹³ See list of references, no. 46.

¹⁴ See list of references, no. 5.

APPENDIX I: ANNEX I

NURSING SURVEY

HOSPITALS QUESTIONNAIRE (POSTAL SURVEY)

Please answer the questions either by ticking the box opposite the answer which applies to you, or by writing in your answer.

Please answer *all* the questions, unless we have said that they only apply to certain kinds of people. This questionnaire has had to be designed so that all different kinds of nurses and midwives, senior and junior, can answer it. We realise that this will mean that some questions will be difficult for some people, but please try to answer them all as applying to you.

At the end there is a space for you to comment either on the questionnaire as a whole or on particular questions. We would welcome any comments you have.

Your answers are needed urgently. Please complete the questionnaire as soon as possible, and then post it off at once in the stamped addressed envelope provided.

Now please turn to question 1 on the back of this page.

- 1(a) How many *complete days* did you get completely free of duty in your last full working week (from Monday through to Sunday)?
Please enter the number ☐ 13
- (b) And how many *half days* did you have off, apart from the full days?
Please enter the number ☐ 14
- (c) And how many *evenings* did you have free, (including days when you had the whole or half day off) in your last full working week?
Please enter the number ☐ 15
- 2(a) About how often do you get a *full day* off on a *Saturday*, not even on call?
Almost every week ☐
Three times a month ☐
Twice a month ☐
Once a month ☐
Less often or never ☐ 16
Please tick one box
- (b) And about how often do you get a full day off on a *Sunday*?
Almost every week ☐
Three times a month ☐
Twice a month ☐
Once a month ☐
Less often or never ☐ 17
Please tick one box
- 3(a) Thinking again over your last complete working week (from Monday through to Sunday) how long were you officially working, including *paid* overtime? Please don't include meals and coffee breaks.
Hours Minutes
Please enter the number of hours and minutes in the week 19-22
- (b) Apart from your paid hours, did you spend any *more* time actually at work (apart from meal and coffee breaks) over your last complete working week? (If you did not work any extra time, please enter "0")
Hours Minutes
Please enter the number of hours and minutes 23-26
- (c) Do you normally have to work extra time of this sort, or not?
Please tick one box Yes, I do ☐
No, I don't ☐ 27
- (d) Apart from time spent actually working, did you spend any hours *on call*, over your last complete working week? (If you did not spend any hours on call, please enter "0")
Hours Minutes
Please enter the number of hours and minutes 28-31
- 4(a) Different nurses work at different times of day. Could you tick the system which most closely describes the way *your own* hours of work are arranged at the moment?
Please tick one box I work the same hours every day ☐
I work on a shift system, with hours of work changing regularly from day to day, week to week or month to month ☐
I work on a different system (Please describe it)
.....) ☐ 32
- (b) On a full working day, do you always work straight through, or does your off-duty come in the middle of a spell?
Please tick one box I always work straight through ☐
I have off-duty in the middle once a week ☐
I have off-duty in the middle 2 or 3 times a week ☐
I have off-duty in the middle more than 3 times a week ☐ 33

(c) For each of the three main times of day shown below, would you firstly tick those when you are ever on duty under your present system; and then for each one you have ticked, enter the number of hours you normally work on a spell at that time?

	<i>Please tick the times when you are ever on duty</i>	<i>Please enter the number of hours in a spell</i>	
Daytime			34
Evening			35–36
Overnight			37–38
			39–40

If you never do any night duty, please skip to question 5 overleaf.
If you ever do any night duty, please answer these questions below.

(d) How is your night duty organised? Please tick the method which comes closest to your own system.

	I always work at night	<input type="checkbox"/>	
	I work at night for a <i>month or more</i> at a time a certain number of months per year	<input type="checkbox"/>	
<i>Please tick one box</i>	I work at night for about <i>a week</i> at a time, a certain number of weeks per month	<input type="checkbox"/>	
	I work at night a certain number of <i>days</i> per week	<input type="checkbox"/>	41

(e) How many weeks in total would you work at night if your present system ran for a full year?

Please enter the number of weeks per year ☐ 42–43

(f) Which system of night duty would you prefer?

	I would prefer always to work at night	<input type="checkbox"/>	
	I would prefer to work at night for a month or more at a time	<input type="checkbox"/>	
<i>Please tick one box</i>	I would prefer to work at night for about a week at a time	<input type="checkbox"/>	
	I would prefer to work at night a certain number of days per week	<input type="checkbox"/>	44

(g) In your last working week (Monday to Sunday) did you work entirely at night, partly at night, or not at all at night?

<i>Please tick one box</i>	Entirely at night	<input type="checkbox"/>	
	Partly at night	<input type="checkbox"/>	
	Not at all at night	<input type="checkbox"/>	45

5(a) Do you work on a duty rota?

<i>Please tick one box</i>	Yes	<input type="checkbox"/>	
	No	<input type="checkbox"/>	46

If you do not have a duty rota, please skip to question 6 below.
If you do have a duty rota, please answer these questions.

(b) How far in advance do you know your weekly duty rota?

	The same day or the day before	<input type="checkbox"/>	
	A few days before	<input type="checkbox"/>	
<i>Please tick one box</i>	A week before	<input type="checkbox"/>	
	2 or 3 weeks before	<input type="checkbox"/>	
	A month or more before	<input type="checkbox"/>	47

(c) Once the duty rota is drawn up, does it usually stay the same, or are changes often made?

<i>Please tick one box</i>	Usually stays the same	<input type="checkbox"/>	
	Changes often made	<input type="checkbox"/>	48

(d) When the duty rotas are being drawn up, do you have any say about when you will have time off?

<i>Please tick one box</i>	Yes	<input type="checkbox"/>	
	No	<input type="checkbox"/>	49

- (e) If on a particular day you wanted to swap your times of duty with another nurse, would you normally be allowed to?
Please tick one box
- Yes ☐ 50
 No ☐

- (f) During the past *month*, have you been sent at all to a different ward, department or nursing unit to "help out"? If so, how many times?
Please tick one box
- Not at all ☐
 Once or twice ☐
 3-5 times ☐
 6-10 times ☐
 More than 10 times ☐ 51

- 6 Nurses sometimes complain that they are being asked to do things which someone else ought really to do. For each of these types of hospital staff, listed below, would you say whether in the *last week*, you have done work which ought really to have been done by them?
Please tick all which apply
- Messengers ☐
 Clerical staff ☐
 Domestic staff ☐
 More highly qualified nurses than you ☐
 Less highly qualified nurses than you ☐
 Doctors ☐
 Social Workers ☐
 Other professional or technical staff ☐
 None of these ☐ 52

YOUR OPINIONS ON NURSING

7(a) Can you say why you decided to take up nursing in the first place?

.....

.....

.....

.....

57

(b) Now you are in nursing, what would you say are the main advantages of the job for you?

.....

.....

.....

.....

58

(c) And what are the disadvantages of the job?

.....

.....

.....

.....

59

8 Thinking about nursing in general, whether in hospitals or for local authorities, which *one* of the following statements best describes the way you feel about nursing work?

- | | | | |
|----------------------------|--|--------------------------|--|
| <i>Please tick one box</i> | It's the only type of work that could really satisfy me | <input type="checkbox"/> | |
| | It's one of several types of work which I could find almost equally satisfying | <input type="checkbox"/> | |
| | There are several types of work I can think of which would be more satisfying | <input type="checkbox"/> | |
| | I have not really considered whether there are other more satisfying types of work | <input type="checkbox"/> | |

60

9(a) How happy would you say you are in your work?

- | | | | |
|----------------------------|-------------------------------|--------------------------|--|
| <i>Please tick one box</i> | Very happy in your work | <input type="checkbox"/> | |
| | Quite happy in your work | <input type="checkbox"/> | |
| | Not very happy in your work | <input type="checkbox"/> | |
| | Not at all happy in your work | <input type="checkbox"/> | |

61

(b) And how happy would you say most of the *other* nurses at your level are in their work?

- | | | | |
|----------------------------|--------------------------------|--------------------------|--|
| <i>Please tick one box</i> | Very happy in their work | <input type="checkbox"/> | |
| | Quite happy in their work | <input type="checkbox"/> | |
| | Not very happy in their work | <input type="checkbox"/> | |
| | Not at all happy in their work | <input type="checkbox"/> | |

62

10 Would you say that prospects for promotion for nurses at your level are very good, quite good or not very good?

- | | | | |
|----------------------------|---------------|--------------------------|--|
| <i>Please tick one box</i> | Very good | <input type="checkbox"/> | |
| | Quite good | <input type="checkbox"/> | |
| | Not very good | <input type="checkbox"/> | |

63

Here are some criticisms which nurses have made to us. Would you say how strongly you agree or disagree with each, so far as your own hospital is concerned?

<i>Please tick one box in each line</i>		Agree Strongly	Agree	Disagree	Disagree Strongly	
(i)	Not enough effort is made to find out what nurses think	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
(ii)	Routine tends to be more important than the welfare of the patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	64
(iii)	Not enough care is taken to keep nurses informed about what is going on	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
(iv)	Too much responsibility for difficult decisions about the care of patients is left to nurses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	65
(v)	There is too much variation in levels of responsibility from day-to-day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
(vi)	At night-time, it is often difficult to get in touch with a senior person when a problem comes up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	66
(vii)	Even in the day-time, it is often difficult to get in touch with a senior person when a problem comes up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
(viii)	Compared with Registered Nurses, Enrolled Nurses don't get enough credit for the work they do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	67
(ix)	Hospital nurses and local authority nurses do not work closely enough together	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
(x)	Part-time nurses should take a fairer share of the difficult hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	68
(xi)	There should be better promotion prospects for part-timers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
(xii)	Administration and training of nurses are less satisfying than direct patient care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	69
(xiii)	There are not enough opportunities for Enrolled Nurses, and Nursing Assistants and Auxiliaries to train for better jobs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
(xiv)	A nurse's career can often be unfairly damaged by a "bad report"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	70
(xv)	Senior nurses often forget what it was like to be a junior nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	71

YOUR PRESENT JOB

11(a) Which one of these categories describes your present post ?
Please tick just one box

Registered Nurse	Staff nurse	<input type="checkbox"/>	
	Charge nurse, Ward Sister or Departmental Sister	<input type="checkbox"/>	
	Unqualified tutor	<input type="checkbox"/>	
	Registered Clinical Instructor	<input type="checkbox"/>	
	Registered tutor	<input type="checkbox"/>	
	Nursing or administrative post above the rank of ward sister	<input type="checkbox"/>	
Enrolled Nurse	Senior Enrolled nurse	<input type="checkbox"/>	
	Enrolled nurse	<input type="checkbox"/>	72
Training to be a Nurse	Unregistered student nurse	<input type="checkbox"/>	
	Post-registration student nurse	<input type="checkbox"/>	
	Pupil nurse	<input type="checkbox"/>	
Midwife	Midwifery Sister	<input type="checkbox"/>	
	Certified midwife	<input type="checkbox"/>	
	Pupil midwife	<input type="checkbox"/>	
Nursing Assistant or Auxiliary	Nursing assistant	<input type="checkbox"/>	
	Nursing auxiliary	<input type="checkbox"/>	73

(b) If your present post does not fit any of these categories, please describe your post as fully as possible.

.....

.....

12(a)	When did you first start on the grade you have ticked above, regardless of which hospital?		
	Please enter the month and year, 19.....		74-76
(b)	If you have had any gaps in service in that grade since then, when did you start on your present spell in the grade, regardless of which hospital?		78-80
	Please enter the month and year, 19.....		7-9
13	When did you start work for your present hospital or hospital group, regardless of which grade. (If you have had any gaps in service, please give the date of beginning on your present spell.)		
	Please enter the month and year, 19.....		10-12

YOUR PREVIOUS JOBS

- 14(a) Have you ever had any experience at all of working for a *local authority*, as a nurse?
Please tick one box Yes ☐ No ☐ 13

IF YOU HAVE

- (b) How long *in total* have you spent nursing for a local authority?
Please tick one box Less than a month ☐
 1-3 months ☐
 4-12 months ☐
 1-3 years ☐
 More than 3 years ☐ 14

- 15(a) Which, if any, of these nursing jobs have you ever had?
Please tick all which apply Agency nurse ☐
 Occupational Health nurse ☐
 Armed forces or prison service nurse ☐
 Other *public* nursing job ☐
 Other *private* nursing job ☐
 Nursing outside Great Britain ☐
 None of these ☐ 15

(b) *IF YOU HAVE EVER WORKED IN ANY OF THESE JOBS*

- How long in total have you spent in them?
Please tick one box Less than a month ☐
 1-3 months ☐
 4-12 months ☐
 1-3 years ☐
 More than 3 years ☐ 16

- 16(a) Did you have any job *before* you ever became a nurse?
Please tick one box Yes ☐ No ☐

- (b) *IF YOU DID* Please describe any jobs you had.

..... 17

- 17(a) *Since* you first became a nurse, have you ever had a spell *outside* nursing, when you had a full-time or part-time job.

- Tick any box which applies* Yes, I have had a full-time job outside nursing ☐
 Yes, I have had a part-time job outside nursing ☐
 Neither of these ☐

IF YOU HAVE

- (b) Please describe any jobs you had.

..... 18

- (c) How long, in total, have you spent in jobs outside nursing since you first became a nurse?

- Please tick one box* Less than 1 month ☐
 1-3 months ☐
 4-12 months ☐
 1-3 years ☐
 More than 3 years ☐ 19

18(a) Since you first became a nurse, have you ever had a spell when you were *not* working at all?

Yes ☐
No ☐ 20

IF YOU HAVE

(b) How long, in total, have you spent not working at all, since you first became a nurse?

Please tick one box

Less than 1 month ☐
1-3 months ☐
4-12 months ☐
1-3 years ☐
More than 3 years ☐ 21

IF YOU ARE NOT PRACTISING AS A MIDWIFE AT THE MOMENT

19(a) Have you ever practised as a certified midwife, either in a hospital or for a local authority?

Tick any box which applies

Yes, in a hospital ☐
Yes, for a local authority ☐
Neither of these ☐ 22

IF YOU HAVE

(b) How long, in total, have you spent practising as a midwife?

Please tick one box

Less than 1 month ☐
1-3 months ☐
4-12 months ☐
1-3 years ☐
More than 3 years ☐ 23

YOUR TRAINING

- 20(a) Have you ever taken any nurses' training courses at all
 or are you taking any at the moment? 24
If you have never taken any training courses, please skip to Question 21 on the next page.
If you have taken any training courses, please answer the questions on this page.

- (b) Here is a list of training courses you might have taken. In the first column would you tick the ones you have *successfully completed*? In the next column, please tick any course you may have started, but *failed to complete*; in the third column, please tick any which you are *taking at the moment*.

	<i>Successfully completed</i>	<i>Failed to complete</i>	<i>Taking at the moment</i>
<i>Training for the Register</i>			
General	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sick children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sub-Normality or Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Training for the Roll</i>			
General	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sub-Normality or Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Training as a Midwife</i>			
Part I	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Part II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
One year or Integrated Course	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Community Training</i>			
Health Visitor Certificate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
District Nurse Certificate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S.E.N. Certificate in District Nursing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Other Post-Certificate Training</i>			
Management { First line	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Middle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Senior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical course	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administration course	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Course leading to registration as a clinical teacher, nurse tutor, public health tutor, midwife teacher or fieldwork instructor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Any other training</i>			
<i>(Please describe)</i>			
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	25-26	27-28	29-30

YOUR FUTURE CAREER

- 21 In two years' time, what do you think is the most likely job that you will be doing?
- The same job ☐
- A similar job in another hospital ☐
- A higher grade in a hospital ☐
- A local authority nursing job ☐
- Another nursing job ☐
- A job outside nursing ☐
- No job at all ☐ 31
- Please tick one box*
- 22(a) Do you work full-time or part-time at the moment?
- Full-time ☐
- Part-time ☐ 32
- Please tick one box*
- (b) How likely is it that you will change from full-time to part-time, or from part-time to full-time, during the next two years?
- Very likely ☐
- Likely ☐
- Not likely ☐ 33
- Please tick one box*
- 23 **UNMARRIED WOMEN ONLY**
- If you were to get married, which one of these would you most want to do, within the first year?
- Stay in your present job ☐
- Change to shorter hours ☐
- Change to another hospital ☐
- Change to local authority nursing ☐
- Change to a job outside nursing ☐
- Give up work altogether ☐ 34
- Please tick one box*
- 24 **MARRIED WOMEN ONLY**
- Suppose you were to have a baby (or another baby), which of these things would you most want to do?
- Come back to your present job as soon as you were fit ☐
- Come back, with shorter hours, as soon as you were fit ☐
- Come back to nursing when the youngest child was a toddler ☐
- Come back to nursing when the youngest child went to school ☐
- Come back to nursing later on ☐
- Never come back to nursing ☐ 35
- Please tick one box*
- 25 For each of these possibilities, could you say whether you are seriously considering it, and if so, whether you have applied to do so?
- Please answer each of the five sections on this page.*
- (a) Taking further training courses, apart from compulsory courses?
- Yes, I have applied for a course ☐
- Yes, I am seriously considering it ☐
- No, I am not seriously considering it ☐ 36
- Please tick one box*
- (b) Going to work as a local authority nurse?
- Yes, I have applied for training or a post ☐
- Yes, I am seriously considering it ☐
- No, I am not seriously considering it ☐ 37
- Please tick one box*
- (c) Going to work as a nurse outside Britain?
- Yes, I have applied for a post ☐
- Yes, I am seriously considering it ☐
- No, I am not seriously considering it ☐
- Please tick one box*

If you are seriously considering it, or if you have applied for a post, which country would you be most likely to go to?

..... 38

- (d) Getting a job outside nursing altogether? 38
- Please tick one box*
- | | | |
|---------------------------------------|--------------------------|----|
| Yes, I have applied for a job | <input type="checkbox"/> | |
| Yes, I am seriously considering it | <input type="checkbox"/> | |
| No, I am not seriously considering it | <input type="checkbox"/> | 39 |

- (e) Giving up work altogether? 40
- Please tick one box*
- | | | |
|---------------------------------------|--------------------------|----|
| Yes, the date is planned | <input type="checkbox"/> | |
| Yes, I am seriously considering it | <input type="checkbox"/> | |
| No, I am not seriously considering it | <input type="checkbox"/> | 40 |

BACKGROUND INFORMATION

26(a) In which country were you born?

Please tick one box

- | | | |
|---------------------------|--------------------------|----|
| England | <input type="checkbox"/> | |
| Scotland | <input type="checkbox"/> | |
| Wales | <input type="checkbox"/> | |
| Northern Ireland | <input type="checkbox"/> | |
| Another country..... | <input type="checkbox"/> | 41 |
| <i>(Please say which)</i> | | |

(b) If you were not born in England, Scotland or Wales, how old were you when you first came here to live?

Please enter how old you were..... 42-43

(c) What is your present nationality?

Please write in..... 44

(d) In which country was your father born?

Please tick one box

- | | | |
|---------------------------|--------------------------|----|
| England | <input type="checkbox"/> | |
| Scotland | <input type="checkbox"/> | |
| Wales | <input type="checkbox"/> | |
| Northern Ireland | <input type="checkbox"/> | |
| Another country..... | <input type="checkbox"/> | 45 |
| <i>(Please say which)</i> | | |

27(a) What type of school were you at mostly after the age of 11?

Please tick one box

- | | | |
|--------------------------------------|--------------------------|----|
| Overseas school..... | <input type="checkbox"/> | |
| Scottish school..... | <input type="checkbox"/> | |
| English or Welsh School: Independent | <input type="checkbox"/> | |
| Direct grant | <input type="checkbox"/> | |
| Grammar | <input type="checkbox"/> | |
| Secondary Modern | <input type="checkbox"/> | |
| Comprehensive | <input type="checkbox"/> | |
| Another school..... | <input type="checkbox"/> | 46 |
| <i>(Please describe)</i> | | |

(b) How old were you when you left your last full-time school or college?

Please enter how old you were ☐ 47-48

28(a) Which, if any, of these United Kingdom exam qualifications did you obtain at school or college? *(Please tick the highest qualification obtained)*

- | | |
|---|--------------------------|
| C.S.E. | <input type="checkbox"/> |
| "O" level, or School Certificate | <input type="checkbox"/> |
| "A" level, or Higher School Certificate | <input type="checkbox"/> |
| Degree | <input type="checkbox"/> |
| None of these | <input type="checkbox"/> |

(b) Please describe any other exam qualifications you obtained at school or college.

..... 49

(c) *IF YOU PASSED "O" LEVEL (OR ITS EQUIVALENT)*

How many subjects did you pass in?

Please enter the number of passes ☐ 50

29(a) Were you ever a Nursing Cadet in a British hospital?

Please tick one box

- | | | |
|-----|--------------------------|----|
| Yes | <input type="checkbox"/> | |
| No | <input type="checkbox"/> | 51 |

(b) Did you ever attend a pre-nursing course at school or college?

Please tick one box

- | | | |
|-----|--------------------------|----|
| Yes | <input type="checkbox"/> | |
| No | <input type="checkbox"/> | 52 |

(c) Have you ever had any other form of training or apprenticeship for a *non-nursing* career?

Please tick one box

- | | |
|-----|--------------------------|
| Yes | <input type="checkbox"/> |
| No | <input type="checkbox"/> |

(d) If you have, please describe it.

53

30(a) How old were you when you got your first job or training post *in nursing*?

Please write in how old you were ☐ 54-55

31 Could you tell us:

(a) Your age last birthday?

Please enter your age..... 56-57

(b) Your sex?

Please tick one box

Male ☐

Female ☐ 58

(c) And your marital status?

Please tick one box

Single ☐

Engaged ☐

Married ☐

Widowed, Separated or Divorced ☐ 59

32(a) Was either of your parents in one of these jobs?

Nurse ☐

Doctor ☐

Please tick any which apply

Other hospital job ☐

Other health job ☐

Neither parent had any of these jobs ☐ 60

(b) *IF YOU ARE MARRIED*

Is your husband's or wife's job any of these?

Nurse ☐

Doctor ☐

Please tick one box

Other hospital job ☐

Other health job ☐

None of these ☐ 61

33(a) Have you any children?

Please tick one box

Yes ☐

No ☐ 62

IF YOU HAVE ANY CHILDREN:

(b) How many do you have?

Please enter the number ☐ 63

(c) What are the ages of your oldest and youngest children? (If you only have one, enter it as the oldest)

Please enter their ages

Oldest ☐ 64-65

Youngest ☐ 66-67

34(a) Where do you live at the moment?

In a nurses' hostel ☐

In other accommodation provided by the hospital ☐

In another kind of hostel ☐

Please tick one box

In a private house ☐

In a private flat ☐

In lodgings ☐ 68

(b) And who do you live with?

With your parents ☐

With your husband or wife ☐

Please tick any which apply

With other relatives ☐

With other nurses ☐

With another friend or friends ☐

On your own ☐ 69

35(a) Do you belong to any of these?

Please tick any which apply

Royal College of Nursing ☐

Royal College of Midwives ☐

Another professional association (*Please say which.....*) ☐

A registered trades union (*Please say which.....*) ☐

None of these ☐ 72

If you have any comments at all on this questionnaire, it would be very helpful to us if you wrote them down here:

188 78-80

Thank you very much indeed for your help. Now please return the questionnaire in the stamped addressed envelope, to:

SOCIAL AND COMMUNITY PLANNING RESEARCH
16 DUNCAN TERRACE
LONDON N1 8BZ

APPENDIX I: ANNEX II

NURSING SURVEY

HOSPITALS QUESTIONNAIRE (INTERVIEW SURVEY)

SERIAL NUMBER.....

- 1(a) SHOW CARD C¹ FOR "PHYSICAL ILLNESSES"
SHOW CARD C² FOR "MENTAL ILLNESSES"
Can you tell me why you decided to take up nursing patients with physical/mental illnesses, as opposed to.....illness? Here are some reasons we have been given.
CODE ALL THAT APPLY IN GRID BELOW:
- (b) *IF MORE THAN ONE MENTIONED* (18-19)
Which of those reasons was the most important?
- | | (a)
All | (b)
One |
|--|------------|------------|
| I particularly wanted to work with this type of patient | 1 | 1 |
| I felt that my services were most needed in this type of nursing | 2 | 2 |
| This type of hospital was most convenient to where I lived | 3 | 3 |
| The pay was better (MENTAL ONLY) | 4 | 4 |
| Another reason..... | 5 | 5 |
| Don't know | 6 | 6 |
- 2(a) SHOW CARD D
Going back to when you started nursing, how did you decide which hospital to start at? CODE ALL THAT APPLY IN GRID BELOW.
- (b) *IF MORE THAN ONE MENTIONED:* (20-21)
Which one of those reasons was the most important?
- | | (a)
All | (b)
One |
|---|------------|------------|
| It was very convenient to my home | 1 | 1 |
| It was the most convenient hospital offering the right kind of training | 2 | 2 |
| It had a good reputation | 3 | 3 |
| I particularly wanted to work in that town or city | 4 | 4 |
| I wanted to work a long way from home | 5 | 5 |
| I knew people who worked there | 6 | 6 |
| Another reason..... | 7 | 7 |
| Don't know | 8 | 8 |
- 3(a) Where in fact were you living just before you first took up nursing? (22)
Town or Nearest Town.....
County..... (23)
- (b) And where was the hospital at which you trained or started nursing? (24)
Town or Nearest Town.....
County..... (25)
- (c) RECORD ADDRESS OF PRESENT HOSPITAL. IF AS (b) SAY "AS (b)" (26)
Town or Nearest Town.....
County.....
- 4 Thinking now of the time when you came to work at your present hospital, or hospital group—how many hospitals or groups did you apply to at about that time? (27)
- | | |
|---------------------------------|---|
| Only 1 | 1 |
| 2-3 | 2 |
| 4-6 | 3 |
| 7-10 | 4 |
| 11+ | 5 |
| "I didn't apply, I was invited" | 6 |

- 5

And when you came to work here, how did you find out about this hospital, and that there might be a vacancy here? DO NOT PROMPT, BUT PROBE FOR PRECISE ANSWER.

(28)

Through friends	{ Nursing	1
	{ Non-nursing	2
Through advertising	{ Nursing press	3
	{ National press	4
	{ Local press	5
	{ Other	6
Through the Labour Exchange		7
Through school		8
It was a well known hospital		9
I lived nearby		0
Other.....		X

- 6(a)

Are you living on the hospital site at present, or elsewhere?

(29)

On site	1
Elsewhere	2

IF ELSEWHERE

- (b)

How do you *normally* get to work?

Car driver	4
Car passenger	5
Train/Tube	6
Hospital bus	7
Public bus	8
Bicycle/Scooter	9
On foot	0
Other.....	X

IF TRAIN/TUBE OR BUS

- (c)

How much do you spend in an average week on fares?

(30) (31) (-)

Pounds & Pence £

ALL TRAVELLING TO WORK

- (d)

About how long does it take you to get to work normally?

(32) (-)

No. of Minutes

- (e)

Would you say the bus service to and from this hospital was very good, quite good, not very good or poor?

(33)

Very good	1
Quite good	2
Not very good	3
Poor	4
Don't know	5

S.E.N. AND PUPILS ONLY

- 7(a)

When you started nursing, did you apply to take the three year training to be a Registered Nurse?

(34)

Yes	1
No	2
Can't remember	3

IF NO

- (b)

Why not?

(35)

PROBE
 AND
 RECORD
 FULLY

AUX/ASS'T. ONLY

- 8(a) When you first started training, did you receive any initial training, immediately after you arrived?

Yes1

No2

Can't remember3

(36)
- (b) And have you had any (other) training since then?

Yes1

No2

Can't remember3

(37)

RECENT SISTER/STAFF	}	ASK THIS SECTION
RECENT S.E.N.		
TRAINEE		
SENIOR	}	SKIP TO Q.16, Page 7.
NOT-RECENT SISTER/STAFF		
NOT-RECENT S.E.N.		
AUX/ASS'T		

9(a) SHOW CARD E

Can we turn to some questions about your training? Looking at this card, which of these phrases best describes what you think/thought *in general* of: (38-42)

READ OUT IN TURN

	Very good	Quite	Not very good	Poor	D.K.	Not App.
Teaching by tutors?	1	2	3	4	5	6
Lectures given by doctors?	1	2	3	4	5	6
Teaching by clinical teachers?	1	2	3	4	5	6
Instruction on the wards from staff nurses and sisters?	1	2	3	4	5	6
(b) Out of class?	1	2	3	4	5	6

(b) And which phrase would you use to describe the willingness of most tutors and instructors to help you out of class, and answer questions?

CODE IN GRID ABOVE

10 Would you say that: (43-44)

	Yes defin- itely	Yes just about	Not at all
(a) You are/were given enough time for studying on your own?	1	2	3
(b) The lectures on theory in class link/linked up well with the practical work on the wards?	5	6	7
(c) You are/were generally given enough time on each ward to get enough experience of that type of work?	1	2	3
(d) All aspects of a trained nurse's work are/were covered by the course?	5	6	7

IF NO AT (d) (45)

(e) Which aspects would you want more training on?

.....

.....

(f) Do/did you feel that there should be more training in managing a ward, or should that be left until after basic training is completed? (46)

More management training	1
Left until after basic training	2
Don't know	3

11(a) Thinking now about the balance between learning in class and working on the wards, do you think: READ OUT (47)

Too much time is/was spent on the wards	1
or Too much time is/was spent in class	2
or The balance is/was just about right	3
Don't know	4

(b) And when you are/were on the wards, what about the balance between learning about nursing, and actually getting on with the work of the ward; do you think: READ OUT (48)

Too much time is/was spent on learning	1
or Too much time is/was spent on actually working	2
or The balance is/was just about right	3
Don't know	4

12(a) *SHOW CARD F*

On this card is a list of things about training courses which some nurses want to see improved. Which *one* aspect do you think most needs improving in the future. (50-56)

	(a) One Aspect (49)	Better	Same	(b) Worse	D.K.
The quality of teaching in classes	1	1	2	3	4
The supervision of practical work	2	1	2	3	4
The quality of teaching on the wards	3	1	2	3	4
The time allowed for studying	4	1	2	3	4
The link between theory and practice	5	1	2	3	4
The length of time for training on each ward	6	1	2	3	4
The balance between learning and actually working	7	1	2	3	4

STAFF/SISTER & SEN ONLY

- (b) And for *each* of the items on the card, do you think that, compared with your own training, things are better nowadays, worse nowadays or about the same as then.

CODE IN GRID ABOVE

13 *SHOW CARD G*

This card describes three ways in which classes can be organised.

Can you say:

- (a) Which of these systems applies/applied to you?

- (b) Which do you think would be best?

	(a) Applies	(b) Best
Block system	1	1
Study days system	2	2
Modular system	3	3
Don't know	4	4

- 14(a) Some people have suggested that student and pupil nurses should be given the status of University or College students. Thinking only of *student nurses*, do you think that this would be: READ OUT FROM GRID BELOW.

- (b) And thinking of *pupil nurses*, do you think that it would be:

READ OUT FROM GRID.

	(a) Student nurses	(b) Pupil nurses
A very good idea	1	1
Quite a good idea	2	2
Not a very good idea	3	3
Not at all a good idea?	4	4
Undecided	5	5
No idea at all/D.K.	6	6

IF NO IDEA AT ALL TO BOTH (a) AND (b) *SKIP TO 13*
OTHERWISE ASK (c)

- (c) In actual practice, what do you think the status of University or College students would mean for nurses? Would it mean? READ OUT IN TURN

	Yes	No	Can't say	
(i) There would be a Students Union?	1	2	3	(61)
(ii) There would be no discipline over students and pupils in off-duty hours?	1	2	3	(62)
(iii) Students and pupils would learn theory in college, not in the hospital?	1	2	3	(63)
(iv) Students and pupils would never do night-duty?	1	2	3	(64)

- | | | | | |
|---|---|---|---|------|
| (v) Students and pupils would only work in the wards to get practice; they wouldn't help staff the wards? | 1 | 2 | 3 | (65) |
| (vi) They would be free to organise their own hours of study? | 1 | 2 | 3 | (66) |
| (vii) They would get a government grant, instead of being paid a salary? | 1 | 2 | 3 | (67) |

15(a) Some nurses say that the *only* place to learn about nursing is in the hospital; others have said that it would be best if the *theory* was taught at a technical college. Which do you think is right? (68)

- | | |
|---------------------------|---|
| Only place is in hospital | 1 |
| Theory in college | 2 |
| Don't know | 3 |

(b) Apart from the quality of training, would you have *liked* to learn at a technical college, along with other students, or do you prefer to learn only with other nurses? (69)

- | | |
|--|---|
| Prefer technical colleges | 1 |
| Prefer to learn only with other nurses | 2 |
| Don't know | 3 |

16(a) *ALL RESPONDENTS*

Can we turn now to some questions about pay, and hours of work? First, can you tell me what is your present basic salary, before deductions for tax and insurance and living in charges. Please don't include any special allowances or overtime payments. (70-71)

O.U.O.

£..... per £ (72)

OVERCODE: NOT SURE OF AMOUNT 1

(b) Thinking of your own pay, would you say it was very reasonable, quite reasonable, not very reasonable or not at all reasonable? (73)

- | | |
|-----------------------|---|
| Very reasonable | 1 |
| Quite reasonable | 2 |
| Not very reasonable | 3 |
| Not at all reasonable | 4 |
| Don't know | 5 |

17(a)] Now, about hours; there are a number of complaints which have been made:

SHOW CARD H: For each one, could say whether you agree or disagree with the complaint as it affects you personally. Card 4 Spare P188 (6)

- | | Agree
strongly | Agree
slightly | Disagree
slightly | Disagree
strongly | Don't
know |
|--|-------------------|-------------------|----------------------|----------------------|---------------|
| (i) You are too often asked to work extra at the end of a shift, without being paid for it | 1 | 2 | 3 | 4 | 5 |
| (ii) You do too much night duty | 1 | 2 | 3 | 4 | 5 |
| (iii) The shift-system is a bad one | 1 | 2 | 3 | 4 | 5 |
| (iv) You don't get enough proper week-ends off | 1 | 2 | 3 | 4 | 5 |
| (v) There are too many last minute changes in the off-duty rota | 1 | 2 | 3 | 4 | 5 |
| (vi) There are not enough opportunities to earn extra, on paid overtime | 1 | 2 | 3 | 4 | 5 |

SHOW CARD I

- (b) Which of these statements comes closest to your view? READ OUT (13)
- (i) Difficulties over shifts, night-duty and so on are just part of nursing, and we will have to accept them 1
 - (ii) These difficulties are the same all over the country—the government or the Whitley Council should do something about them 2
 - (iii) It is up to the hospital administration to get rid of difficulties over shifts, night duty, and so on 3
 - (iv) Difficulties of this sort are usually the responsibility of the Sister on the ward 4
 - Don't know 5

18 SHOW CARD J

Looking at this card, which *one* of these things would you most like to see improved? And which would you choose second after that? (14–15)

	1st	2nd
More basic pay	1	1
A reduction of hours in the working week	2	2
Less night duty	3	3
More weekends off	4	4
No extra duties without payment	5	5
Better shift-systems	6	6
Better notice of changes in off-duty	7	7
Better allowances for special duties	8	8
More opportunities to earn extra money on paid overtime	9	9
Don't know	0	0

- 19(a) Thinking of the duties you are asked to do, do you feel that you have to do: READ OUT IN TURN.

	Yes Defin- itely	Yes slightly	No	(b)
(i) Work which you have not yet been trained to do?	1	2	3	(16)
(ii) Too much non-nursing work, like domestic duties?	1	2	3	(17)
(iii) Too much basic nursing work—like bedmaking, bedpans and so on?	1	2	3	(18)
(iv) Too much night duty?		2	3	(19)

- (b) FOR EACH ITEM ANSWERED "YES DEFINITELY"

Who do you think should be doing that sort of work?

RECORD IN GRID ABOVE

- 20(a) Going back to pay, thinking of the nursing profession as a whole, do you think that levels of pay are very reasonable, quite reasonable, not very reasonable or not at all reasonable. (20)

Very reasonable	1
Quite reasonable	2
Not very reasonable	3
Not at all reasonable	4
Don't know	5

- 21(a) Now some questions about nursing as a career. Apart from any changes in the type of work you might do, would you be happy to stay in your present grade or would you like to be promoted? (21)

Stay in present position	1
Like to be promoted	2
Don't know	3

IF LIKE TO BE PROMOTED

- (b) Which of all the grades in the hospital would you most like to reach eventually if you had the opportunity? (22)
DO NOT PROMPT.

S.E.N.	1
Senior S.E.N.	2
Staff Nurse	3
Charge Nurse/Sister/"No. 6"	4
"No. 7"	5
Matron/Assistant Matron/No. 8, 9, 10	6
Tutorial grades 7-9	7
Don't know	8

SHOW CARD K

- 22(a) What do you think about *auxiliaries or assistants* who would like to become S.E.N.'s after a few years experience. Which of these do you think should happen? READ OUT PRECODES FROM GRID.
- (b) And what about *S.E.N.'s* who would like to become registered nurses after a few years experience? READ OUT (23-24)

	Aux. or SEN's Ass'ts.	
They should stay where they are	1	1
or They should take the full training course	2	2
or They should take a special, shorter course	3	3
or They should be promoted on the basis of their experience and performance	4	4
Don't know	5	5

SHOW CARD L

- 23(a) Thinking now about nurses *at about your own level*, who might decide to take extra training. How much do you think they should be paid? READ OUT. (25)
- The pay for the trainees on that course regardless of the individual's experience 1
- or The pay that each individual would have been earning if she hadn't taken the course 2
- or Extra pay, to encourage more people to do it 3
- Don't know 4

THIS PAGE FOR SENIOR, SISTER/STAFF, AND S.E.N. ONLY

24 *SHOW CARD M*

Could you say how strongly you agree or disagree with each of these statements about the career structure. (26-30)

	Agree strongly	Agree slightly	Dis- agree slightly	Dis- agree strongly	D.K.
(a) Nurses who take extra qualifications ought to get extra pay automatically	1	2	3	4	5
(b) Promotion tends to be based too often on length of service, instead of on ability	6	7	8	9	0
(c) There are not enough opportunities to take further training courses	1	2	3	4	5
(d) There ought to be more opportunities to specialise in particular types of nursing	6	7	8	9	0
(e) There ought to be more information and advice available for nurses who want to further their careers	1	2	3	4	5
<i>EXCLUDE S.E.N.'s</i>					
(f) Not enough encouragement is given to take up teaching	6	7	8	9	0
(g) There ought to be senior grades for those who want to continue with actual nursing of patients	1	2	3	4	5
(h) Promotion is very slow once one has passed the level of sister/charge nurse	6	7	8	9	0
(i) Not enough nurses are prepared to accept promotion above the level of sister/charge nurse	1	2	3	4	5

25	Would you yourself like to take a training course of some sort if the chance came up?				(31)
				Yes	1
				No	2
				Don't know	3

SHOW CARD N

26 Now I'd like to ask you some questions about the actual work of looking after the patient. If you look at the card, there are two main ways listed of organising the day-to-day work on the ward?

READ OUT ITEMS (i) AND (ii) FROM GRID BELOW. THEN ASK EACH QUESTION IN TURN, AND RECORD IN GRID

- Which is closest to your own system, or don't you work in a ward situation?
- Which is the most efficient and best to organise—from Sister's point of view?
- Which would be best from the point of view of teaching students and pupils?
- Which would be best from the point of view of giving the patient the best medical treatment?
- Which would be best for the comfort and welfare of the patient?
- Which would be best from your own personal point of view of enjoying your work?

(32-37)

	(a) Own system	(b) Ef- ficient	(c) Teach- ing	(d) Treat- ment	(e) Com- fort	(f) Per- sonal
(i) Different nurses are organised to do one particular job at a time, for all the patients on the ward	1	1	1	1	1	1

(ii) Nurses are given a group of patients to look after, and do all the jobs for those patients	2	2	2	2	2	2
(iii) Both equally	3	3	3	3	3	3
Don't know/Not applicable	4	4	4	4	4	4

27(a) Some nurses feel that they should get to know their patients personally, and even use Christian names in cases; others feel that the best care is given if there is a more formal atmosphere. Which would you tend to agree with, on the whole?
RECORD IN GRID BELOW.

	(a)	(b)	
	Prefer	Exists	(38-39)
Get to know patients personally	1	1	
More formal atmosphere	2	2	
Combination of the two	3	3	
Don't know	4	4	

28(a) I am going to read out some complaints which nurses have made about problems which occur in treating patients. For each one, could you say whether it often applies to this hospital or not?

	Applies				Serious				
	Not		D.K.		Not		D.K.		
	Ap-plies	ap-plies			Very	Quite	very		
(i) There are too many interruptions in the middle of a task.	1	2	3	4	5	6	7	(40)	
(ii) Many of the nurses have not been trained well enough in their duties.	1	2	3	4	5	6	7	(41)	
(iii) There are problems with doctors, nurses or patients who don't speak English very well	1	2	3	4	5	6	7	(42)	
(iv) Many nurses are just not interested in their work	1	2	3	4	5	6	7	(43)	
(v) Nursing is hindered by petty rules and discipline	1	2	3	4	5	6	7	(44)	
(vi) There is a shortage of supporting staff in the wards	1	2	3	4	5	6	7	(45)	
(vii) There is not enough supervision of junior nurses in their work	1	2	3	4	5	6	7	(46)	
(viii) Nurses are just too busy to do all the work they have to do	1	2	3	4	5	6	7	(47)	
(ix) There are too many junior nurses, compared with fully qualified ones	1	2	3	4	5	6	7	(48)	
(x) Poor administration means that the best use is not made of the nurses' time	1	2	3	4	5	6	7	(49)	
(xi) Nursing is hampered by lack of proper equipment	1	2	3	4	5	6	7	(50)	

FOR EACH ITEM ANSWERED "YES, IT APPLIES"

(b) *SHOW CARD O*
How serious an affect do you think this has on the treatment of patients?

CODE IN GRID ABOVE

29 In hospital there are lots of other nurses like you, to make friends with. How important would you say this was in making nursing a happy job? Is it:— (51)

READ OUT

- Very important 1
- Quite important 2
- Not very important 3
- or Not at all important 4
- ("It's true, but nursing isn't a happy job") 5
- Don't know 6

30 Some nurses have said to us that there is an unhappy atmosphere between senior or junior nurses, while others say that there is a very good relationship.

(a) In the ward or department where you work, would you say that senior and junior nurses get on very well with each other, or quite well, or not very well or not at all well with each other. (52-53)

	(a) Ward	(b) Hosp.
Very well	1	1
Quite well	2	2
Not very well	3	3
Not at all well	4	4
Don't know	5	5

(b) And in the hospital as a whole, would you say that senior and junior nurses get on very well with each other, quite well, not very well or not at all well with each other?

CODE IN GRID ABOVE

31(a) Some nurses think that the only way to run a hospital is to maintain firm discipline, with senior nurses keeping apart from juniors; others think that the best way is if everyone is as friendly as possible. Which view would you take? (54)

- Firm Discipline 1
- Friendly as possible 2
- Combination of the two 3
- Don't know 4

(b) In this hospital do you:

	Yes	No	D.K.	Very good thing	Quite a good thing	Not a good thing	D.K.
							(55-56)
(i) Address other nurses by Christian names?	1	2	3	4	5	6	7
(ii) Sit at meals by separate grades?	1	2	3	4	5	6	7

(c) FOR EACH ABOVE:
Would you say that it was a very good thing, quite a good thing or not a good thing that you do/don't?

CODE IN GRID ABOVE

SHOW CARD P

32 For each of these grades of nurse could you tell me whether on the whole:

(a) Most of them are as keen on their work as they ought to be?

(b) Most of them treat nurses of your grade with politeness and respect?

ASK FOR EACH GRADE EXCEPT RESPONDENT'S OWN (COUNT (i) &

(ii) AS "SENIOR") (57-63)

	(a) Keen				(b) Respect				D.K.	N.A.
	Yes defin- itely	Yes just about	Not really	Defi- nitely not	Yes defin- itely	Yes just about	Not really	Defi- nitely		
(i) Administrative Nurses	1	2	3	4	6	7	8	9	0	X
(ii) Teaching Nurses	1	2	3	4	6	7	8	9	0	X
(iii) Staff Nurses and Sisters	1	2	3	4	6	7	8	9	0	X
(iv) Students	1	2	3	4	6	7	8	9	0	X
(v) S.E.N.'s	1	2	3	4	6	7	8	9	0	X
(vi) Pupils	1	2	3	4	6	7	8	9	0	X
(vii) Auxiliaries or Assistants	1	2	3	4	6	7	8	9	0	X

33* I am going to read out some words and phrases which nurses have sometimes used about the grades above them. In general, can you say whether each one applies to the nurses above *you*? Would you say they are:— READ OUT IN TURN (64-73)

	Yes, it applies	No it doesn't	Can't say
Friendly	1	2	3
Too much concerned with their status?	1	2	3
Apt to make a fuss over minor things?	1	2	3
Jealous of other nurses?	1	2	3
Sympathetic to your problems?	1	2	3
Good leaders of a team?	1	2	3
Polite?	1	2	3
Difficult to talk to?	1	2	3
They take care to keep us informed about what's going on?	1	2	3
They tend to give the best jobs to people they like?	1	2	3
			Spare 188

Card 5 (7)

34† And now some words and phrases which nurses have used about the grades below them. In general, can you say whether each one applies to the nurses below *you*? READ OUT IN TURN. (8-15)

	Yes, it applies	No, it doesn't	Can't say
Keen on their work?	1	2	3
Irresponsible?	1	2	3
Careless?	1	2	3
Polite?	1	2	3
Too friendly?	1	2	3
Immature?	1	2	3
Lazy?	1	2	3
Too much concerned with their status?	1	2	3

† Exclude assistants and auxiliaries.

STAFF/SIS./SEN ONLY

35* Comparing the students (pupils) of today with those who were training at the same time as you, do you think:— (16)

(a) The students (pupils) of today are more keen on their work, less keen on their work or about the same as they used to be?

More keen	1
Less keen	2
About the same	3
Don't know	4

(b) The students (pupils) of today are more respectful to their seniors, less respectful to their seniors, or about the same as they used to be? (17)

More respectful	1
Less respectful	2
About the same	3
Don't know	4

(c) And comparing the staff nurses (S.E.N.'s) of today with those who were above you when you were training, would you say they are more friendly towards the juniors, less friendly towards the juniors, or about the same as they used to be? (18)

More friendly	1
Less friendly	2
About the same	3
Don't know	4

ALL SHOW CARD PACK Q

36 On these cards there are several grades of nurses. Regardless of the *official* position, could you put them in the order of the responsibility that you think they ought to be given? Who ought to be given the most responsibility? And who would come next? Etc. (19-26)

WRITE IN RANK ORDER FROM 1 to 8.

A staff nurse with one year's experience
A third year student
A first year student
An S.E.N. with 5 years' experience
An S.E.N. with 1 year's experience
A first year pupil
An auxiliary or assistant with 10 years' experience
An auxiliary or assistant with 1 year's experience

37 SHOW CARD R

I am going to read some complaints about relations between nurses. Looking at the card, could you say how strongly you agree or disagree with each of them?
READ OUT EACH IN TURN. (27-28)

	Agree strongly	Agree slightly	Dis- agree slightly	Dis- agree strongly	D.K.
(a) If you make a good suggestion about how something should be done, they take no notice	1	2	3	4	5
(b) If you complain about something, they just label you as a trouble maker	6	7	8	9	0
(c) The senior nurses in administration are out of touch with problems of nursing on the wards	1	2	3	4	5
(d) If a junior nurse is unhappy about something, the senior nurse isn't interested	6	7	8	9	0

38	Would you say that most of your friends are nurses, or are most non-nurses, or is it about half and half?	(29)
	Most are nurses	0
	Most are non-nurses	1
	About half and half	2

39 *CARD R AGAIN*
 And here are some things that nurses have said about working with doctors.
 How far do you agree or disagree with these. (30-31)

	Agree strongly	Agree slightly	Dis- agree slightly	Dis- agree strongly	D.K.
(i) When doctors discuss patients with nurses, they take no account of the nurse's skill and experience	1	2	3	4	5
(ii) Doctors <i>should</i> always talk to the most senior nurse on duty, even though she may not have been so closely involved with the patient	6	7	8	9	0
(iii) In fact, doctors always <i>do</i> talk to the most senior nurse on duty	1	2	3	4	5

QUESTIONS 40 & 41 FOR SENIOR STAFF ONLY

- 40 Now some questions particularly about senior nurses. Firstly, about the influence of senior nurses on other aspects of the hospital.

SHOW CARD S

Could you tell me how satisfactory you think Nurses' level of influence is over: (32-34)

READ OUT IN TURN

	Very	Quite	Not very	Not at all	D.K.
(a) Administrative policy?	1	2	3	4	5
(b) Medical policy?	1	2	3	4	5
(c) Ancillary services?	1	2	3	4	5

41(a) STILL CARD S

And what about nursing policy. For each of the aspects I am going to mention, could you tell me whether you find the present policy satisfactory? (35-45)

READ OUT IN TURN	(a) Policy					(b) Influence				
	Very	Quite	Not very	Not at all	D.K.	Very	Quite	Not very	Not at all	D.K.
(i) Standardisation of nursing procedures	1	2	3	4	5	6	7	8	9	0
(ii) Allocation of staff on the wards	1	2	3	4	5	6	7	8	9	0
Organisation of shifts and off duties	1	2	3	4	5	6	7	8	9	0
(iv) Recruitement of trainees	1	2	3	4	5	6	7	8	9	0
(v) Selection and appointment of trained staff	1	2	3	4	5	6	7	8	9	0
(iv) System of patients records	1	2	3	4	5	6	7	8	9	0
(vii) Admissions and discharges	1	2	3	4	5	6	7	8	9	0
(viii) Maintenance of staff records	1	2	3	4	5	6	7	8	9	0
(ix) Coordination between teaching and staffing	1	2	3	4	5	6	7	8	9	0
(x) Organisation of training courses	1	2	3	4	5	6	7	8	9	0
(xi) Communication with sister and staff nurse levels	1	2	3	4	5	6	7	8	9	0

- (b) FOR EACH ABOVE:
And for each one could you say whether you think your *own influence* over that policy is satisfactory?

ALL RESPONDENTS

- 42 What do you think about community nurses, who work for local authorities, like district nurses, health visitors and domiciliary midwives—do you respect them very much, quite a bit, not very much or not at all? (46)

Very much	1
Quite a bit	2
Not very much	3
Not at all	4
Don't know	5

(b) Why do you say that?

(47)

(c) Would you ever consider working as a local authority nurse ? PROBE. Definitely or probably?

(48)

Yes, definitely1

Yes, probably2

No, probably not3

No, definitely not4

Don't know5

(d) I am going to read out some things which have been said about local authority nursing. For each one, could you tell me (A) whether you think it is true? IF YES (B) and if so, whether you think it is an advantage or a disadvantage?

(49-57)

CARD T FOR B

	True?		Advantage		Dis- Un- Un- advantage			
	Yes	No	D.K.	Imp.	imp.	imp.	Imp.	D.K.
(i) You could get on with treating the patient without interference from doctors and senior nurses	1	2	3	4	5	6	7	8
(ii) You would get left behind on new methods of treatment, outside the hospital	1	2	3	4	5	6	7	8
(iii) You would get to know the patients properly in their own homes	1	2	3	4	5	7	7	8
(iv) You would lose the friendly spirit of the hospital	1	2	3	4	5	6	7	8
(v) There would be a feeling of belonging to the community you are serving	1	2	3	4	5	6	7	8
(vi) There would be a lack of proper facilities and supporting staff	1	2	3	4	5	6	7	8
(vii) You would get away from the rather closed-in and formal atmosphere of the hospital	1	2	3	4	5	6	7	8
(viii) You would only get simple cases to look after—only basic nursing	1	2	3	4	5	6	7	8
(ix) It would be easier to combine nursing with running a home	1	2	3	4	5	6	7	8

43

Finally, some questions about married women and nursing. *In general*, what do you think about married women going out to work, whether they are nurses or not.

SHOW CARD U

On this card are some opinions people have expressed. I should like you to tell me which statement comes closest on the whole to your own opinion.

- (a) If the woman has no children.....READ OUT PRECODES
- (b) If her children are all at school.....READ OUT PRECODES

(c) If she has children under school age.....READ OUT PRECODES (58-60)

	(a) No child- ren	(b) School child- ren	(c) Young child- ren
She ought to go out to work if she is fit	1	1	1
or She has the right to work if she wants to	2	2	2
or She should only work if she needs money	3	3	3
or She ought to stay at home	4	4	4
Can't say	5	5	5

IF MARRIED AND FEMALE

- 44(a) Would you say it was very difficult, quite difficult, not very difficult or not at all difficult to have a job and run a home at the same time? (61)
- | | |
|----------------------|---|
| Very difficult | 1 |
| Quite difficult | 2 |
| Not very difficult | 3 |
| Not at all difficult | 4 |
| Don't know | 5 |

IF VERY OR QUITE DIFFICULT, CHECK FULLTIME FILTER, AND ASK (b)

IF FULL-TIME AS WELL

- (b) Why don't you work part-time? PROBE FULLY. (62)

.....

.....

.....

ALL

- 45 Do you think it is fair on the other nurses that married women should be allowed to work part-time at the hours which are convenient to them? (63)
- | | |
|-----------------|---|
| Perfectly fair | 1 |
| Fair | 2 |
| Not very fair | 3 |
| Not at all fair | 4 |
| Don't know | 5 |

IF PART-TIME (QUESTION 46 ONLY)

- 46 Do you think that your present arrangement of hours of work are very satisfactory, quite, not very, or not at all satisfactory? (64)
- | | |
|------------|---|
| Very | 1 |
| Quite | 2 |
| Not very | 3 |
| Not at all | 4 |
| Don't know | 5 |
- 47 What about women coming back after a gap when they were having children. Do you think they should be encouraged to come back? (65)
- | | |
|--------------------|---|
| Yes, definitely | 1 |
| Yes, probably | 2 |
| No, not really | 3 |
| No, definitely not | 4 |
| Don't know | 5 |

SHOW CARD V

- (b)

Suppose a Sister left nursing to have children, and came back five years later; do you think:— READ OUT

(66)
- She should be given her old job back at once

1
- She should be made a staff nurse, but be promoted fairly quickly

2
- She should be made a junior staff nurse, and wait her turn for promotion

3
- She should be made a third year student, to learn about new developments in nursing

4
- Can't say

5

48

Last of all,

(67-68)

- (a)
- Could you give me the details of your father's occupation?

PROBE FULLY.....

.....

.....

IF MARRIED

- (b)
- And could you give me details of your husband's/wife's occupation?
- (69-70)

.....

.....

.....

ALL

- (c)
- Suppose for some reason you couldn't have been a nurse at all. Can you say what job you would have been most likely to have chosen instead?
- (71- 72)

PROBE FULLY.....

.....

.....

Spare 73-77

188 (78-80)

APPENDIX II

INDIVIDUALS AND BODIES¹ WHO SUBMITTED EVIDENCE

* *Denotes individuals or bodies submitting oral as well as written evidence.*

† *Denotes individuals or bodies submitting oral evidence only.*

Mr. E. Aherne

Miss H. O. Allen

Dr. M. Allen

Mr. E. Alleyne

Mr. C. G. E. Alterskye

Mr. R. Amer

Miss J. Ansell

Mr. S. Armitage

Ashton, Hyde and Glossop Hospital Management Committee

Association for Improvements in the Maternity Services

Association for the Psychiatric Study of Adolescents

Association for the Welfare of Children in Hospital (Wales)

* Association of British Paediatric Nurses

Association of County Councils in Scotland

Association of Directors of Education in Scotland

* Association of District Nurses

Association of Headmistresses (Scottish Branch)

Association of Hospital Management Committees

Association of Hospital Management Committees, Welsh Regional Branch

Association of Hospital Therapists

Association of Hospital and Residential Care Officers

Association of Integrated and Degree Courses in Nursing

Association of Municipal Corporations

* Association of Nurse Administrators

Association of Occupational Therapists

Association of Psychiatric Nurse Tutors, Scotland

Association of Secretaries and Treasurers of Scottish Hospital Boards of Management

Association of Supervisors of Midwives

Association of Teachers in Colleges and Departments of Education

Mr. J. F. Baker

Mr. A. H. Baldwin

Miss M. E. Baly

Miss H. Banks

Dr. A. Barr

¹ Where it has come to our notice that a body has changed its name during the currency of our Committee, we have in all cases listed it under the name by which it was known at the date of writing our Report.

Barrow and Furness Hospital Management Committee
 Miss J. C. E. Bates
 Bath Hospital Management Committee
 Miss N. Battersby
 Miss J. Battle
 Mrs. M. Bedard
 Miss E. Bendall
 Miss G. Bennett
 Miss K. Bennett
 Miss J. Beresford
 Bethlem Royal Hospital and the Maudsley Hospital—Board of Governors
 Mrs. M. Beveridge
 Mr. S. K. Bickley
 Birmingham Regional Hospital Board
 Mrs. A. Black
 Blackburn and District Hospital Management Committee
 Blackpool and Fylde Hospital Management Committee
 Miss L. A. Blades
 Dr. S. Bockner
 Dr. F. G. Bolton
 Bolton and District Hospital Management Committee
 Miss A. C. Bone
 Booth Hall and Monsall Hospital Management Committee
 Miss M. W. Bourne
 Mr. G. F. Bowman
 Miss M. Brain
 British Association of Social Workers
 * British Dietetic Association
 British Geriatrics Society
 British Geriatrics Society Scottish Branch
 * British Medical Association
 British Orthopaedic Association
 British Orthopaedic Association and Central Council for the Disabled—Joint
 Examination Board
 * British Paediatric Association and British Association of Paediatric Surgeons
 British Red Cross Society
 British Thoracic and Tuberculosis Association
 Brockhall Hospital Management Committee
 Dr. A. C. D. Brown
 Mrs. R. Bryant
 Mrs. A. Buchanan
 Miss Y. E. Buckoke
 Burnley and District Hospital Management Committee
 Bury and Rossendale Hospital Management Committee
 Miss A. Butterworth
 Mrs. M. Byron

 Calderstones Hospital Management Committee
 Campaign for the Mentally Handicapped
 * Central Midwives Board
 * Central Midwives Board for Scotland

Mr. P. Chamberlain
 Mr. I. V. Chandler
 Charing Cross Group of Hospitals—Board of Governors
 Chartered Society of Physiotherapy
 Cheltenham Hospital Group Management Committee
 Sir R. Chesterman
 Miss K. Chisholm
 Miss J. A. Clark
 Mr. R. A. Clark
 Claybury Hospital Management Committee
 Professor J. Clutton-Brock
 Clwyd and Deeside Hospital Management Committee—Nurse Training
 Sub-Committee
 Mr. T. J. Coady
 Coatbridge, Airdrie and District Hospitals—Board of Management
 Miss P. Coen
 Dr. N. F. Coghill
 Mrs. M. Colley
 Commonwealth Students' Children Society
 * Committee of Directors of Polytechnics
 Committee of Vice-Chancellors and Principals of the Universities of the
 United Kingdom
 Confederation of Health Service Employees
 Mrs. M. A. McK. Connechen
 Dr. M. B. Conran
 Mr. C. J. Cooper
 Mrs. E. L. Coote
 Mr. F. A. Couch
 * Council for the Education and Training of Health Visitors
 * Council for Professions Supplementary to Medicine and related Boards
 * Council for Training in Social Work
 Counties of Cities Association, Scotland
 County Councils Association
 Mr. J. Cox
 Miss W. E. Coxon
 Miss J. Craig
 Cranage Hall Hospital Management Committee
 Miss J. Cross
 Crothall and Company Limited
 Miss H. Cruse
 Mr. J. K. Cubbin

 Professor R. D'Aeth
 Mr. B. S. Davies
 Professor J. Davies
 Mrs. M. Davies
 Mr. H. J. Dellar
 Mrs. H. J. Dent
 * Department of Education and Science
 Department of Employment
 * Department of Health and Social Security

Mr. D. A. Dickson
Disabled Living Foundation
District Nursing Administrators and Tutors Group
Lady Donaldson
Mr. A. C. Doyle
Dundee College of Nursing (Education Management Committee)
Durham Hospital Management Committee

East Anglian Regional Hospital Board
East Cheshire Hospital Management Committee
East Liverpool Hospital Management Committee
Eastern Regional Hospital Board (Scotland)
Mr. C. F. Edmondson
Mr. J. A. Edwards
Mr. H. W. Eisel
Miss A. Ellis
Mr. D. G. Elson
Employment Agents Federation of Great Britain—Nurses Section
Enterprise Youth

Faculty of Radiologists—Royal College of Surgeons of England
Family Planning Association
Mr. D. Fannon
Mr. L. H. Farnsworth
Mr. J. Faulkner
Mr. C. Fawcett
Miss E. Few
Dr. J. G. Field
Miss B. L. Fletcher
Miss M. A. Fletcher
Dr. H. M. Foreman
Mr. T. French
Miss D. M. Fuchner

Mr. T. Gallagher
Dr. I. Gardner
Mrs. V. Gartland

* General Nursing Council for England and Wales (Incl. Area Nurse-Training Committees)

* General Nursing Council for Scotland

Mr. P. Ghey
Miss B. Goodfellow
Mrs. M. Goodhand
Mrs. C. M. Green
Mr. J. Greene
Mrs. D. E. Greenall
Lord Grenfell

† Dr. K. Grunewald

Guild of Public Pharmacists

Mr. P. V. Guy

Guys Hospital—Board of Governors

- Mr. J. D. Haldane
Miss B. Hall
Dr. P. Hall-Smith
Hammersmith and St. Mark's Hospitals—Senior Nursing Staff
Miss B. Hansen
Mr. M. J. Harfst
Mr. C. J. Harries
Miss B. Hart
Mrs. B. Hayes
Mr. S. C. Haywood
* Health Education Council Limited
Health Services Joint Advisory Committee for Livingstone Area
* Health Visitors Association
Mrs. A. P. Henderson
Mr. J. Henderson
Miss M. A. Hibbert
Miss P. Hibbs
Mrs. B. M. Hill
Mr. M. J. Hill
Mrs. S. Hitherington
Mr. E. C. Hoffard
Miss E. M. Holmes
Horton Hospital Management Committee
Hospital for Sick Children, Great Ormond Street—Board of Governors
Dr. C. J. Hughes
Miss E. J. Hull
Humanist Nurses' Organisation
Miss J. Hunt
Miss M. Hunt
Dr. H. Hunter
Mr. M. Hunter
Mrs. N. Hurd
- * Institute of Health Service Administrators
Institutional Management Association—Council of Management
International Confederation of Midwives
International Planned Parenthood Federation
International Round Table for the Advancement of Counselling
Inverness Hospitals—Board of Management
Dr. D. H. Irvine
- Mr. G. M. Jackson
Miss I. J. Jackson
Miss E. G. James
* Joint Board of Clinical Nursing Studies
* Joint Executive Committee of the Associations of Headmasters, Headmistresses, Assistant Masters and Assistant Mistresses (The Joint Four)
Miss L. M. Jones
Mrs. M. Jones
* Junior Hospital Doctors' Association

Mr. M. Kendall
Kent Nursing Association
Mr. O. F. G. Kilgour
Mr. C. N. King
King Edward's Hospital Fund for London
King's College Hospital Group—Board of Governors
Miss M. Kirk
Miss H. Kitson
Mrs. S. Kitzinger

Mr. C. Lake
Miss W. Lamond
Mr. F. S. Lawlor
Lea Castle Hospital Action Committee
Leeds Regional Hospital Board
Mrs. F. M. Leenders
Miss J. Leslie
Mr. K. Lewis
Library Advisory Council (England)
Library Association
Liverpool Regional Hospital Board (Planning Committee—Nursing Advisory Council)
Mr. T. Lodge
London Boroughs Training Committee (Social Services)
Mr. M. Loughnane
Miss D. H. Lynn

Miss E. Macintyre
Miss J. C. Mackeith
Miss P. Mackenzie
Dr. N. Malleson
Manchester Regional Hospital Board
Mr. J. K. Mansfield
Miss D. J. Marchant
Marie Curie Memorial Foundation
Mr. J. W. Marshall
Miss S. N. Marson
Mr. W. W. Martin
Miss C. Masset
Maternity and Infant Care Association
Miss O. Mathews
Miss M. Mathie
Miss P. Maxwell
Mr. R. Maynard
Miss S. Mazepa
Mr. M. McBrien
Dr. M. McDonald
Mr. P. C. McIlurath
Mr. J. McRoberts

- Dr. S. R. Meadow
Medway and Gravesend Hospital Management Committee
Miss G. Meers
Dr. L. S. Michealis
Middlesex Hospital—Board of Governors
Mid-Somerset Hospital Management Committee
Midwife Teachers Training College Council
Mid-Wilts Hospital Management Committee
Miss M. E. Miles
Miss A. Milton
Dr. A. M. Michie
Miss V. J. Molland
Mrs. D. Moore
Mr. J. Moore
* Mr. B. Moores
Moorhaven Hospital Management Committee
Mrs. M. E. Morgan
Miss M. J. Morgan
Mr. J. R. W. Morrice
Lord Morris
Mr. M. C. T. Morrison
Mothers in Action
Mrs. P. Moys
Mrs. P. Murphy
- * National Association of Chief and Principal Nursing Officers (Psychiatric)
National Association of Head Teachers
National Association of Hospital Management Committee Group Secretaries
* National Association of Leagues of Hospital Friends
National Association for Mental Health
National Association of Theatre Nurses of Great Britain
National Association for the Welfare of Children in Hospital
National Childbirth Trust
National Council of Social Service
National Hospitals for Nervous Diseases—Board of Governors
National and Local Government Officers Association
* National Nursing Staff Committee
* National Society for Mentally Handicapped Children
National Union of Public Employees
National Union of Students
Mr. C. A. N. Neal
† Mr. B. Neilson
Newcastle Regional Hospital Board
North East Metropolitan Regional Hospital Board
North Eastern Regional Hospital Board (Scotland)
North Lancashire and South Westmorland Hospital Management Committee
North Manchester Hospital Management Committee
North West Metropolitan Regional Hospital Board
Nursing and Hospital Careers Advisers, King's College Hospital Group
Miss P. Nuttall

Mr. J. O'Hara
Oakmere Hospital Management Committee
Oldham and District Hospital Management Committee
Mr. N. J. O'Leary
Ophthalmic Nursing Board
Miss G. M. Owen
Oxford Regional Hospital Board (Nursing Services Committee)

Mr. A. Palmer
Mrs. A. Palmer
Mrs. G. Palmer

* Panel of Assessors for District Nurse Training

Miss J. Parkinson

* Patients Association

Dr. J. W. Paulley

Mr. R. Payne

Mr. E. Peacock

Professor J. H. Peacock

Mr. L. Pearce

Miss M. J. Penfold

Mr. A. D. Pennell

Miss A. Penny

Mr. H. Pickett

Political and Economic Planning

† Mrs. R. Pomeranz

Mrs. M. Preston

Preston and Chorley Hospital Management Committee

Prestwich Hospital Management Committee

Dr. J. Price

Prudhoe and Monckton Hospital Management Committee

Queen Charlotte's and Chelsea Hospitals—Board of Governors

* Queen's Institute of District Nursing

Miss A. L. Rattee

* Regional Nursing Officers (Regional Hospital Boards in England and Wales)

Miss J. Redgeon

Dr. B. Reedy

Mr. J. Reid

Relatives of the Mentally Ill

Mr. S. Richardson

Professor A. G. Riddell

Mrs. D. M. Riddell

Mrs. F. M. Roberts

Mrs. J. Robinson

Mrs. J. A. Robinson

Rochdale and District Hospital Management Committee

Mrs. J. Rose

Mr. N. D. Ross

Miss S. G. Ross

Mrs. P. R. Rowley

Royal Albert Hospital Management Committee
 * Royal College of General Practitioners
 * Royal College of Midwives
 * Royal College of Midwives (Scottish Council)
 * Royal College of Nursing and National Council of Nurses of the United Kingdom
 Royal College of Nursing and National Council of Nurses of the United Kingdom (Edinburgh)—Public Health Area Group
 RCN Old Students Association
 RCN Research Discussion Group
 * Royal College of Obstetricians and Gynaecologists
 † Royal College of Obstetricians and Gynaecologists—(Scottish Executive Committee)
 * Royal College of Physicians and Surgeons of Glasgow
 * Royal College of Physicians of Edinburgh
 * Royal College of Psychiatrists
 * Royal College of Surgeons of Edinburgh
 * Royal College of Surgeons of England
 Royal Cornhill and Associated Hospitals Board of Management
 Royal County of Berkshire—Health Department Nursing Staff
 Royal Earlswood Group Hospital Management Committee
 Royal Eastern Counties Group Hospital Management Committee
 Royal Hospital for Sick Children, Edinburgh—Nursing Staff
 Royal Hospital of St. Bartholomew—Board of Governors
 Royal Marsden Hospital—Board of Governors
 Royal National Orthopaedic Hospital—Board of Governors
 Royal National Throat, Nose and Ear Hospital—Board of Governors
 Royal Victoria Infirmary, Newcastle-on-Tyne—Board of Governors
 Mr. A. F. Rushforth
 Professor W. R. Russell
 Dr. T. W. Ryan

Salford Hospital Management Committee
 Mr. M. Salont
 Sandhill Park Group Hospital Management Committee
 Miss M. Sands
 Miss B. Saunders
 Mr. C. M. Saunders
 Mr. A. N. Schofield
 Scottish Association of Medical Administrators
 Scottish Association of Nurse Administrators
 * Scottish Council for Health Education
 Scottish Council for Commercial, Administrative and Professional Education
 Scottish Education Department
 Scottish Health Visitors Association
 * Scottish Home and Health Department
 Scottish Hospital Advisory Service
 Scottish Midwives Teachers' Club
 * Scottish Nursing Staffs Committee
 * Scottish Public Health Nursing Administrators and Tutors Group
 Miss E. Senior

Mr. D. Sharpe
 Sheffield Regional Hospital Board
 Mrs. N. Sidford
 Dr. M. Sim
 Miss R. Simpson
 Mr. A. Sinfield
 Professor A. Smith
 Mr. J. P. Smith
 Mr. L. M. Smith
 Mrs. M. E. Smith
 Miss M. P. Smith
 Dr. P. H. Smith
 Miss S. B. Smith
 * Society of Chief Nursing Officers (Public Health)
 Society of Education Officers
 * Society of Medical Officers of Health
 Society of Mental Nurses
 Society of Occupational Medicine at the Royal College of Physicians, London
 Mrs. E. R. Somerville
 South Cheshire Hospital Management Committee
 South East Kent Hospital Management Committee
 South East Metropolitan Regional Hospital Board
 South Eastern Regional Hospital Board (Scotland)
 South Liverpool Hospital Management Committee
 South West Metropolitan Regional Hospital Board
 South Western Regional Hospital Board (England)
 Southmead General Hospital Group Management Committee
 Spastics Society
 Mr. D. C. Speller
 Standing Conference of Representatives of Health Visitor Training Centres
 Steering Committee on University and Nursing Education
 Mrs. A. Stewart
 Miss J. Stewart
 Mr. J. H. Stewart
 Stockport and Buxton Hospital Management Committee
 Stoke Park Group Hospital Management Committee
 St. Georges Hospital, London—Board of Governors
 St. George's Hospital, Morpeth—Senior Nursing Staff
 St. John Ambulance Association and Brigade
 St. Lawrence's Hospital Management Committee
 St. Mary's Hospital, London—Board of Governors
 St. Thomas' Hospital, London—Department of Nursing, and Board of
 Governors
 Mr. G. Strathan
 Mrs. M. Straughan
 Mr. A. H. Sutherland
 Mrs. C. N. Swift

 Mr. E. I. Taylor
 Miss O. E. Taylor
 Teaching Hospitals Association

The London Hospital—Board of Governors
Miss K. Thomas
Mrs. A. H. Thompson
Torquay Hospital Management Committee
Mr. D. Towell
Trades Union Congress—Nursing Advisory Committee
Mrs. J. N. Turnball

United Birmingham Hospitals—Board of Governors
United Bristol Hospitals—Division of Psychiatry
United Kingdom Council for Overseas Student Affairs
United Liverpool Hospitals—Board of Governors
United Manchester Hospitals—Board of Governors
United Oxford Hospitals—Board of Governors
University College Hospital—Board of Governors
University Hospital Management Committee of South Manchester
University of Edinburgh—Department of Nursing Studies
University of Southampton—Department of Sociology and Social Administration
University of Surrey—Biological Sciences Department

Miss W. M. Vacher
Miss H. Vallentine

Mr. A. Wade
Miss J. F. Walker
Mr. M. Walker
Mr. C. J. Wardle
Miss K. Waters
Welsh Hospital Board

* Welsh Office

Wessex Regional Hospital Board
West Cheshire Hospital Management Committee
West Cumberland Hospital Management Committee
West Cornwall Hospital Management Committee
West Manchester Hospital Management Committee
Westminster Hospital Group—Board of Governors
West Riding of Yorkshire—County Divisional Nursing and Midwifery Officers
Mr. J. A. Whitehead
Whittingham Hospital Management Committee
Wigan and Leigh Hospital Management Committee
Dr. J. R. Wilkie
Mrs. R. G. Williams
Mrs. H. Willie
Miss D. Wilmot
Miss E. Wilson
Mrs. H. Wilson
Wolverhampton Technical College—Student Members of Group XI 1967–71
Women's Royal Voluntary Service
Mr. T. A. Wood

Mrs. M. M. Wootton

Mr. R. Wright

Wrightington Hospital Management Committee

Miss F. Wroe

Wythenshawe and North Cheshire Hospital Management Committee

York "A" Hospital Management Committee

Dr. M. E. York Moore

Young Volunteer Force

APPENDIX III

VISITS MADE BY THE COMMITTEE AND ITS RESEARCH STAFF

The following establishments were visited by members of the Committee and/or the research staff:

Adult Training Centre, Bedford
Airedale General Hospital, Yorkshire
Association of Hospital Personnel Officers

Bedfordshire County Council—Local Health Authority
Bedford General Hospital
Bellsdyke Hospital, Larbert
Berkshire County Council—Local Health Authority
Birmingham County Borough—Local Health Authority
Bradford County Borough Council—Local Health Authority
Bromham Hospital, Bedford

Cardiff County Borough Council—Local Health Authority
Cheshire County Council—Local Health Authority
Chichester and Graylingwell Group H.M.C.
Chiswick Polytechnic
Coldeast and Tatchbury Mount H.M.C.
Cornwall County Council—Local Health Authority
Cornwall H.M.C.
Croydon Technical College

Doncaster Royal Infirmary
Dudley Road (Birmingham) H.M.C.

East Birmingham H.M.C.
East Kilbride—Local Health Authority
East Ham Technical College
Edinburgh Corporation—Local Health Authority
Edinburgh Royal Infirmary
Edware General Hospital, London
Epsom and West Park Group H.M.C.

Falkirk and District Royal Infirmary
Filton Technical College, Bristol
Foresterhill College, Aberdeen

Glantawe H.M.C., Swansea
Glasgow Royal Infirmary
Greenwich District General Hospital

Hackney Hospital, London
Hospital for Sick Children—Great Ormond Street

King's College Hospital, London

London Borough of Croydon—Local Health Authority
Lynebank Hospital, Dunfermline

Maythorn Hostel, Biggleswade
Manchester County Borough—Local Health Authority

Newcastle-on-Tyne County Borough—Local Health Authority
Newcastle-on-Tyne H.M.C.
Newcastle-on-Tyne Polytechnic
Norfolk County Council—Local Health Authority
North East Manchester H.M.C.
Northgate and District Hospital, Northumberland
North West Metropolitan Regional Hospital Board
Northwich Park Hospital, Cheshire
Norwich, Lowestoft and Great Yarmouth Group H.M.C.

Portsmouth Group—School of Nursing
Portsmouth Polytechnic

Queen Elizabeth II Hospital, Hertfordshire

Reading County Borough—Local Health Authority
Redhill and Netherne Group H.M.C.
Royal Edinburgh Hospital

St. Andrews and Hellesdon H.M.C.
St. Bartholomew's Hospital, London
St. Catherine's Hospital, Doncaster
St. James' Hospital, Leeds
St. John's Special School, Kempston
St. Thomas' Hospital, London
Sheffield Regional Hospital Board
Sheffield University H.M.C.
Shrewsbury and District H.M.C.
Shropshire Education Committee—Abraham Darby School
Simpson Memorial Maternity Pavilion, Edinburgh
Southampton University H.M.C.
South Ockenden Hospital, Essex
South Western Regional Hospital Board
Surrey County Council—Local Health Authority
Swansea County Borough Council—Local Health Authority

The London Hospital
Tooting Bec Hospital, London
Towers Hospital, Leicester

United Cambridge Hospitals
United Leeds Hospitals
United Liverpool Hospitals
United Oxford Hospitals
United Sheffield Hospitals
University Hospital of Wales (Cardiff) H.M.C.
University of Edinburgh

Wakefield H.M.C.
Walsgrave Hospital, Coventry
Welsh Regional Hospital Board
West Riding of Yorkshire—Local Health Authority
Wessex Regional Hospital Board
West Sussex County Council—Local Health Authority
Whittington Hospital, London

APPENDIX IV
STATISTICAL TABLES

The following tables are included:

1. Nursing and midwifery staff at 30.9.71—analysis by grade, sex and nature of contract.
2. Nursing and midwifery staff at 30.9.71—analysis by grade, sex, nature of contract and type of hospital.

England and Wales

- A. Acute, Mainly Acute and Partly Acute
- B. Long Stay and Mainly Long Stay
- C. Mental Illness
- D. Mental Handicap
- E. Maternity
- F. Other—including geriatric, chronic, etc.

3. Nursing and midwifery staff at 30.9.71—analysis by grade, sex, nature of contract and type of hospital.

Scotland

- A. Mental Illness
- B. Mental Deficiency
- C. Maternity
- D. Other—including geriatric, chronic, etc.

4. Nursing and midwifery staff at 30.9.71—analysis by grade, sex, nature of contract and Region.

- A. Newcastle R.H.B.
- B. Leeds R.H.B.
- C. Sheffield R.H.B.
- D. East Anglian R.H.B.
- E. North-West Metropolitan R.H.B.
- F. North-East Metropolitan R.H.B.
- G. South-East Metropolitan R.H.B.
- H. South-West Metropolitan R.H.B.
- I. Oxford R.H.B.
- J. South Western R.H.B.
- K. Birmingham R.H.B.
- L. Manchester R.H.B.
- M. Liverpool R.H.B.
- N. Wessex R.H.B.

5. Nursing and midwifery staff in teaching hospitals at 30.9.71—analysis by grade, sex and nature of contract.

- A. London undergraduate teaching hospitals
- B. London post-graduate teaching hospitals
- C. Provincial teaching hospitals

6. Nursing and midwifery staff at 30.9.71—analysis by grade, sex and nature of contract.

Wales

7. Nursing and midwifery staff at 30.9.71—analysis by grade, sex and nature of contract.

Scotland

8. Summary of local authority community health nursing staff at 30.9.71.

TABLE 1

**NURSING AND MIDWIFERY STAFF AT 30 SEPTEMBER 1971—ANALYSIS BY GRADE,
SEX, AND NATURE OF CONTRACT
Great Britain**

	<i>Total</i>			<i>Male</i>			<i>Female</i>		
	<i>No. W/T</i>	<i>No. P/T</i>	<i>Total WTE</i>	<i>No. W/T</i>	<i>No. P/T</i>	<i>Total WTE</i>	<i>No. W/T</i>	<i>No. P/T</i>	<i>Total WTE</i>
Total nursing and midwifery	224,602	126,486	303,389·7	34,275	2,703	35,660·2	190,327	123,783	267,729·5
Senior nursing grades	13,133	598	13,504·1	3,504	11	3,509·2	9,629	587	9,994·9
Ward sister/charge nurse	34,654	7,672	39,622·7	8,818	89	8,852·6	25,836	7,590	30,770·1
Staff nurse	20,569	29,231	36,857·5	3,958	1,376	4,603·5	16,611	27,849	32,254·0
Enrolled nurse	28,996	22,071	43,687·1	4,728	345	4,910·9	24,268	21,725	38,776·2
Student nurse (incl. post-reg.)	55,801	—	55,801·0	7,555	—	7,555·0	48,246	—	48,246·0
Pupil nurse	23,851	1,331	24,833·8	2,087	1	2,087·8	21,764	1,330	22,746·0
Other nursing staff	32,284	60,963	71,088·5	3,625	881	4,141·2	28,659	60,082	66,947·3
Senior midwifery grades	1,864	56	1,899·2	—	—	—	1,864	56	1,899·2
Midwifery sister	4,664	1,497	5,590·8	—	—	—	4,664	1,497	5,590·8
Staff midwife	3,159	3,067	4,878·0	—	—	—	3,159	3,067	4,878·0
Pupil midwife	5,627	—	5,627·0	—	—	—	5,627	—	5,627·0

TABLE 2

**NURSING AND MIDWIFERY STAFF AT 30 SEPTEMBER 1971—ANALYSIS BY GRADE,
SEX, NATURE OF CONTRACT AND TYPE OF HOSPITAL**

**England and Wales
A. Acute, Mainly Acute and Partly Acute**

	<i>Total</i>			<i>Male</i>			<i>Female</i>		
	<i>No. W/T</i>	<i>No. P/T</i>	<i>Total WTE</i>	<i>No. W/T</i>	<i>No. P/T</i>	<i>Total WTE</i>	<i>No. W/T</i>	<i>No. P/T</i>	<i>Total WTE</i>
Total nursing and midwifery	107,907	56,601	142,420·8	6,788	378	6,977·0	101,119	56,223	135,443·8
Senior nursing grades	5,370	270	5,532·6	709	4	710·7	4,661	266	4,821·9
Ward sister/charge nurse	15,029	4,017	17,615·3	1,466	19	1,474·5	13,563	3,998	16,140·8
Staff nurse	11,039	16,829	20,390·4	554	109	604·6	10,485	16,720	19,785·8
Enrolled nurse	10,387	8,466	15,963·7	832	66	868·3	9,555	8,400	15,095·4
Student nurse (incl. post-reg.)	35,604	—	35,604·0	2,132	—	2,132·0	33,472	—	33,472·0
Pupil nurse	13,196	814	13,796·3	547	1	547·8	12,649	813	13,248·5
Other nursing staff	9,820	24,030	24,785·7	548	179	639·1	9,272	23,851	24,146·6
Senior midwifery grades	770	27	787·3	—	—	—	770	27	787·3
Midwifery sister	2,396	678	2,817·3	—	—	—	2,396	678	2,817·3
Staff midwife	1,569	1,470	2,401·2	—	—	—	1,569	1,470	2,401·2
Pupil midwife	2,727	—	2,727·0	—	—	—	2,727	—	2,727·0

B. Long Stay and Mainly Long Stay

	<i>Total</i>			<i>Male</i>			<i>Female</i>		
	<i>No. W/T</i>	<i>No. P/T</i>	<i>Total WTE</i>	<i>No. W/T</i>	<i>No. P/T</i>	<i>Total WTE</i>	<i>No. W/T</i>	<i>No. P/T</i>	<i>Total WTE</i>
Total nursing and midwifery	9,794	8,831	15,578·6	1,517	153	1,600·8	8,277	8,678	13,977·8
Senior nursing grades	620	43	647·5	149	2	150·2	471	41	497·3
Ward sister/charge nurse	1,562	516	1,912·4	418	6	420·7	1,144	510	1,491·7
Staff nurse	543	1,251	1,271·2	100	52	125·5	443	1,199	1,145·7
Enrolled nurse	2,221	1,886	3,467·4	339	33	357·5	1,882	1,853	3,109·9
Student nurse (incl. post-reg.)	409	—	409·0	111	—	111·0	298	—	298·0
Pupil nurse	1,424	82	1,486·9	88	—	88·0	1,336	82	1,398·9
Other nursing staff	2,774	4,943	6,080·1	312	60	347·9	2,462	4,883	5,732·2
Senior midwifery grades	39	1	39·9	—	—	—	39	1	39·9
Midwifery sister	111	41	135·5	—	—	—	111	41	135·5
Staff midwife	38	68	75·7	—	—	—	38	68	75·7
Pupil midwife	53	—	53·0	—	—	—	53	—	53·0

C. Mental Illness

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	29,103	11,239	36,340.3	13,289	1,231	13,883.5	15,814	10,008	22,456.8
Senior nursing grades	1,746	6	1,749.3	1,116	1	1,116.5	630	5	632.8
Ward sister/charge nurse	6,690	283	6,873.9	3,633	24	3,641.2	3,057	259	3,232.7
Staff nurse	3,256	2,263	4,493.1	2,092	849	2,474.9	1,164	1,414	2,018.2
Enrolled nurse	5,263	3,786	7,858.7	1,624	102	1,675.2	3,639	3,684	6,183.5
Student nurse (incl. post-reg.)	6,396	—	6,396.0	3,231	—	3,231.0	3,165	—	3,165.0
Pupil nurse	2,582	133	2,677.5	787	—	787.0	1,795	133	1,890.5
Other nursing staff	3,170	4,768	6,291.8	806	255	957.7	2,364	4,513	5,334.1
Senior midwifery grades	—	—	—	—	—	—	—	—	—
Midwifery sister	—	—	—	—	—	—	—	—	—
Staff midwife	—	—	—	—	—	—	—	—	—
Pupil midwife	—	—	—	—	—	—	—	—	—

D. Mental Handicap

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	13,435	6,330	17,624.8	6,036	624	6,375.2	7,399	5,706	11,249.6
Senior nursing grades	930	11	937.5	596	—	596.0	334	11	341.5
Ward sister/charge nurse	2,746	255	2,917.9	1,630	17	1,637.6	1,116	238	1,280.3
Staff nurse	847	714	1,246.1	502	266	632.0	345	448	614.1
Enrolled nurse	2,801	1,759	4,032.3	989	86	1,034.9	1,812	1,673	2,997.4
Student nurse (incl. post-reg.)	1,900	—	1,900.0	948	—	948.0	952	—	952.0
Pupil nurse	985	52	1,021.9	336	—	336.0	649	52	685.9
Other nursing staff	3,226	3,539	5,569.1	1,035	255	1,190.7	2,191	3,284	4,378.4
Senior midwifery grades	—	—	—	—	—	—	—	—	—
Midwifery sister	—	—	—	—	—	—	—	—	—
Staff midwife	—	—	—	—	—	—	—	—	—
Pupil midwife	—	—	—	—	—	—	—	—	—

E. Maternity

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	6,050	4,941	8,941.9	—	—	—	6,050	4,941	8,941.9
Senior nursing grades	32	2	33.5	—	—	—	32	2	33.5
Ward sister/charge nurse	92	25	104.4	—	—	—	92	25	104.4
Staff nurse	162	572	463.6	—	—	—	162	572	463.6
Enrolled nurse	327	551	666.0	—	—	—	327	551	666.0
Student nurse (incl. post-reg.)	265	—	265.0	—	—	—	265	—	265.0
Pupil nurse	26	1	26.6	—	—	—	26	1	26.6
Other nursing staff	842	2,331	2,235.4	—	—	—	842	2,331	2,235.4
Senior midwifery grades	588	20	599.5	—	—	—	588	20	599.5
Midwifery sister	1,306	576	1,659.6	—	—	—	1,306	576	1,659.6
Staff midwife	796	863	1,274.3	—	—	—	796	863	1,274.3
Pupil midwife	1,614	—	1,614.0	—	—	—	1,614	—	1,614.0

F. Other—including geriatric, chronic, etc.

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	28,508	22,188	42,545.3	2,394	213	2,508.7	26,114	21,975	40,036.6
Senior nursing grades	3,007	199	3,127.7	545	3	546.8	2,462	196	2,580.9
Ward sister/charge nurse	4,529	2,027	5,827.8	599	15	606.6	3,930	2,012	5,221.2
Staff nurse	2,145	4,003	4,360.1	188	43	207.5	1,957	3,960	4,152.6
Enrolled nurse	4,160	3,589	6,532.0	393	53	420.0	3,767	3,536	6,112.0
Student nurse (incl. post-reg.)	4,868	—	4,868.0	194	—	194.0	4,674	—	4,674.0
Pupil nurse	2,679	140	2,784.6	100	—	100.0	2,579	140	2,684.6
Other nursing staff	6,249	11,990	14,028.4	375	99	433.8	5,874	11,891	13,594.6
Senior midwifery grades	219	1	219.5	—	—	—	219	1	219.5
Midwifery sister	297	120	371.4	—	—	—	297	120	371.4
Staff midwife	164	119	234.8	—	—	—	164	119	234.8
Pupil midwife	191	—	191.0	—	—	—	191	—	191.0

TABLE 3

NURSING AND MIDWIFERY STAFF AT 30 SEPTEMBER 1971—
ANALYSIS BY GRADE, SEX, NATURE OF CONTRACT AND TYPE OF HOSPITAL

Scotland
A. Mental Illness

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	6,148	1,710	7,268	2,662	76	2,711	3,486	1,634	4,557
Senior nursing grades	363	1	364	220	—	220	143	1	144
Ward sister/charge nurse	1,274	23	1,291	709	—	709	565	23	582
Staff nurse	668	329	870	382	53	412	286	276	458
Enrolled nurse	1,108	283	1,296	356	3	359	752	280	937
Student nurse (incl. post-reg.)	1,096	—	1,096	571	—	571	525	—	525
Pupil nurse	540	—	540	142	—	142	398	—	398
Other nursing staff	1,099	1,074	1,811	282	20	298	817	1,054	1,513
Senior midwifery grades	—	—	—	—	—	—	—	—	—
Midwifery sister	—	—	—	—	—	—	—	—	—
Staff midwife	—	—	—	—	—	—	—	—	—
Student midwife	—	—	—	—	—	—	—	—	—

B. Mental Deficiency

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	2,100	319	2,322	700	12	709	1,400	307	1,613
Senior nursing grades	103	2	104	62	1	62	41	1	42
Ward sister/charge nurse	349	22	366	185	—	185	164	22	181
Staff nurse	135	51	168	76	7	82	59	44	86
Enrolled nurse	329	45	362	79	1	79	250	44	283
Student nurse (incl. post-reg.)	197	—	197	93	—	93	104	—	104
Pupil nurse	155	—	155	38	—	38	117	—	117
Other nursing staff	832	199	970	167	3	170	665	196	800
Senior midwifery grades	—	—	—	—	—	—	—	—	—
Midwifery sister	—	—	—	—	—	—	—	—	—
Staff midwife	—	—	—	—	—	—	—	—	—
Student midwife	—	—	—	—	—	—	—	—	—

C. Maternity

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	3,073	1,821	4,161	—	—	—	3,073	1,821	4,161
Senior nursing grades	—	—	—	—	—	—	—	—	—
Ward sister/charge nurse	—	—	—	—	—	—	—	—	—
Staff nurse	44	110	102	—	—	—	44	110	102
Enrolled nurse	93	87	149	—	—	—	93	87	149
Student nurse (incl. post-reg.)	—	—	—	—	—	—	—	—	—
Pupil nurse	—	—	—	—	—	—	—	—	—
Other nursing staff	500	988	1,116	—	—	—	500	988	1,116
Senior midwifery grades	248	7	253	—	—	—	248	7	253
Midwifery sister	554	82	607	—	—	—	554	82	607
Staff midwife	592	547	892	—	—	—	592	547	892
Student midwife	1,042	—	1,042	—	—	—	1,042	—	1,042

D. Other—including geriatric, chronic, etc.

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	18,484	12,506	26,187	889	16	895	17,595	12,490	25,292
Senior nursing grades	962	64	1,008	107	—	107	855	64	901
Ward sister/charge nurse	2,383	504	2,714	178	1	178	2,205	503	2,536
Staff nurse	1,730	3,109	3,493	64	3	65	1,666	3,106	3,428
Enrolled nurse	2,307	1,619	3,360	116	2	117	2,191	1,617	3,243
Student nurse (incl. post-reg.)	5,066	—	5,066	275	—	275	4,791	—	4,791
Pupil nurse	2,264	109	2,345	49	—	49	2,215	109	2,296
Other nursing staff	3,772	7,101	8,201	100	10	104	3,672	7,091	8,097
Senior midwifery grades	—	—	—	—	—	—	—	—	—
Midwifery sister	—	—	—	—	—	—	—	—	—
Staff midwife	—	—	—	—	—	—	—	—	—
Student midwife	—	—	—	—	—	—	—	—	—

TABLE 4

NURSING AND MIDWIFERY STAFF AT 30 SEPTEMBER 1971— ANALYSIS BY GRADE, SEX, NATURE OF CONTRACT AND REGION

A. Newcastle R.H.B.

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	11,571	5,515	14,983.5	1,917	77	1,956.0	9,654	5,438	13,027.5
Senior nursing grades	637	15	645.9	187	—	187.0	450	15	458.9
Ward sister/charge nurse	1,855	219	1,999.7	498	1	498.2	1,357	218	1,501.5
Staff nurse	1,167	1,665	2,095.3	246	50	273.2	921	1,615	1,822.1
Enrolled nurse	1,827	1,328	2,692.2	298	7	301.2	1,529	1,321	2,391.0
Student nurse (incl. post-reg.)	2,341	—	2,341.0	420	—	420.0	1,921	—	1,921.0
Pupil nurse	1,243	58	1,280.1	94	—	94.0	1,149	58	1,186.1
Other nursing staff	1,796	1,984	3,081.0	174	19	182.4	1,622	1,965	2,898.6
Senior midwifery grades	86	—	86.0	—	—	—	86	—	86.0
Midwifery sister	264	58	299.6	—	—	—	264	58	299.6
Staff midwife	154	188	261.7	—	—	—	154	188	261.7
Pupil midwife	201	—	201.0	—	—	—	201	—	201.0

B. Leeds R.H.B.

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	12,168	7,421	16,784·3	2,457	166	2,542·0	9,711	7,255	14,242·3
Senior nursing grades	717	48	746·1	258	1	258·5	459	47	487·6
Ward sister/charge nurse	1,956	550	2,302·1	593	4	594·7	1,363	546	1,707·4
Staff nurse	918	1,430	1,684·1	262	84	303·1	656	1,346	1,381·0
Enrolled nurse	1,828	1,577	2,861·7	357	23	368·6	1,471	1,554	2,493·1
Student nurse (incl. post-reg.)	2,708	—	2,708·0	553	—	553·0	2,155	—	2,155·0
Pupil nurse	1,644	93	1,713·5	181	—	181·0	1,463	93	1,532·5
Other nursing staff	1,730	3,445	3,941·4	253	54	283·1	1,477	3,391	3,658·3
Senior midwifery grades	94	6	97·8	—	—	—	94	6	97·8
Midwifery sister	274	122	350·5	—	—	—	274	122	350·5
Staff midwife	110	150	190·1	—	—	—	110	150	190·1
Pupil midwife	189	—	189·0	—	—	—	189	—	189·0

C. Sheffield R.H.B.

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	13,567	8,692	19,039·1	2,312	166	2,396·0	11,255	8,526	16,643·1
Senior nursing grades	811	67	854·0	231	1	231·7	580	66	622·3
Ward sister/charge nurse	2,162	631	2,562·1	667	3	668·2	1,495	628	1,893·9
Staff nurse	1,036	1,853	2,026·2	233	102	279·0	803	1,751	1,747·2
Enrolled nurse	2,011	1,681	3,122·9	289	25	302·1	1,722	1,656	2,820·8
Student nurse (incl. post-reg.)	2,663	—	2,663·0	509	—	509·0	2,154	—	2,154·0
Pupil nurse	1,599	67	1,646·7	157	—	157·0	1,442	67	1,489·7
Other nursing staff	2,390	3,998	5,038·1	226	35	249·0	2,164	3,963	4,789·1
Senior midwifery grades	120	7	124·3	—	—	—	120	7	124·3
Midwifery sister	321	156	422·2	—	—	—	321	156	422·2
Staff midwife	168	232	293·6	—	—	—	168	232	293·6
Pupil midwife	286	—	286·0	—	—	—	286	—	286·0

D. East Anglian R.H.B.

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	4,708	3,765	7,033·7	1,074	47	1,097·8	3,634	3,718	5,935·9
Senior nursing grades	329	18	338·8	123	2	124·0	206	16	214·8
Ward sister/charge nurse	758	239	907·6	255	1	255·3	503	238	652·3
Staff nurse	433	841	894·4	123	16	131·5	310	825	762·9
Enrolled nurse	598	566	973·7	141	9	146·0	457	557	827·7
Student nurse (incl. post-reg.)	957	—	957·0	181	—	181·0	776	—	776·0
Pupil nurse	613	88	676·6	72	—	72·0	541	88	604·6
Other nursing staff	742	1,899	1,946·5	179	19	188·0	563	1,880	1,758·5
Senior midwifery grades	40	—	40·0	—	—	—	40	—	40·0
Midwifery sister	102	41	126·4	—	—	—	102	41	126·4
Staff midwife	43	73	79·7	—	—	—	43	73	79·7
Pupil midwife	93	—	93·0	—	—	—	93	—	93·0

E. North-West Metropolitan R.H.B.

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	13,853	6,321	17,702.1	2,309	182	2,402.9	11,544	6,139	15,299.2
Senior nursing grades	843	29	860.1	220	1	220.5	623	28	639.6
Ward sister/charge nurse	2,230	401	2,487.5	554	14	558.6	1,676	387	1,928.9
Staff nurse	1,229	1,981	2,322.6	269	88	311.9	960	1,893	2,010.7
Enrolled nurse	1,537	1,079	2,263.7	277	15	285.0	1,260	1,064	1,978.7
Student nurse (incl. post-reg.)	4,021	—	4,021.0	634	—	634.0	3,387	—	3,387.0
Pupil nurse	1,560	54	1,599.7	163	—	163.0	1,397	54	1,436.7
Other nursing staff	1,399	2,537	2,970.0	192	64	229.9	1,207	2,473	2,740.1
Senior midwifery grades	126	4	129.1	—	—	—	126	4	129.1
Midwifery sister	239	48	270.3	—	—	—	239	48	270.3
Staff midwife	206	188	315.1	—	—	—	206	188	315.1
Pupil midwife	463	—	463.0	—	—	—	463	—	463.0

F. North-East Metropolitan R.H.B.

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	11,924	6,345	15,799.1	1,646	169	1,731.6	10,278	6,176	14,067.5
Senior nursing grades	686	52	717.7	185	—	185.0	501	52	532.7
Ward sister/charge nurse	1,626	372	1,865.3	376	3	377.9	1,250	369	1,487.4
Staff nurse	899	1,591	1,779.7	201	95	247.2	698	1,496	1,532.5
Enrolled nurse	1,334	1,171	2,124.2	206	25	217.1	1,128	1,146	1,907.1
Student nurse (incl. post-reg.)	3,514	—	3,514.0	369	—	369.0	3,145	—	3,145.0
Pupil nurse	1,614	51	1,653.0	123	—	123.0	1,491	51	1,530.0
Other nursing staff	1,308	2,875	3,062.8	186	46	212.4	1,122	2,829	2,850.4
Senior midwifery grades	107	2	107.8	—	—	—	107	2	107.8
Midwifery sister	217	72	262.1	—	—	—	217	72	262.1
Staff midwife	194	159	287.5	—	—	—	194	159	287.5
Pupil midwife	425	—	425.0	—	—	—	425	—	425.0

G. South-East Metropolitan R.H.B.

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	11,719	8,076	16,697.3	2,040	200	2,146.6	9,679	7,876	14,550.7
Senior nursing grades	756	30	772.4	205	—	205.0	551	30	567.4
Ward sister/charge nurse	1,939	485	2,269.0	472	4	474.2	1,467	481	1,794.8
Staff nurse	1,017	2,068	2,157.6	208	80	243.2	809	1,988	1,914.4
Enrolled nurse	1,498	1,378	2,405.7	322	31	339.6	1,176	1,347	2,066.1
Student nurse (incl. post-reg.)	2,811	—	2,811.0	485	—	485.0	2,326	—	2,326.0
Pupil nurse	1,325	171	1,455.8	117	—	117.0	1,208	171	1,338.8
Other nursing staff	1,463	3,698	3,770.5	231	85	282.6	1,232	3,613	3,487.9
Senior midwifery grades	94	3	95.8	—	—	—	94	3	95.8
Midwifery sister	260	63	299.0	—	—	—	260	63	299.0
Staff midwife	181	180	285.5	—	—	—	181	180	285.5
Pupil midwife	375	—	375.0	—	—	—	375	—	375.0

H. South-West Metropolitan R.H.B.

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	12,503	6,592	16,409.4	2,831	423	3,024.1	9,672	6,169	13,385.3
Senior nursing grades	841	23	855.8	254	—	254.0	587	23	601.8
Ward sister/charge nurse	2,355	369	2,595.7	765	13	770.2	1,590	356	1,825.5
Staff nurse	1,196	1,936	2,250.2	414	241	509.4	782	1,695	1,740.8
Enrolled nurse	1,609	1,176	2,361.5	310	48	335.1	1,299	1,128	2,026.4
Student nurse (incl. post-reg.)	3,219	—	3,219.0	713	—	713.0	2,506	—	2,506.0
Pupil nurse	1,371	74	1,423.2	190	—	190.0	1,181	74	1,233.2
Other nursing staff	1,210	2,792	2,872.5	185	121	252.4	1,025	2,671	2,620.1
Senior midwifery grades	80	7	85.0	—	—	—	80	7	85.0
Midwifery sister	198	49	227.8	—	—	—	198	49	227.8
Staff midwife	162	166	256.7	—	—	—	162	166	256.7
Pupil midwife	262	—	262.0	—	—	—	262	—	262.0

I. Oxford R.H.B.

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	5,186	4,647	8,122.0	879	59	910.6	4,307	4,588	7,211.4
Senior nursing grades	371	34	390.7	126	—	126.0	245	34	264.7
Ward sister/charge nurse	914	269	1,087.9	276	3	277.5	638	266	810.4
Staff nurse	437	951	978.1	71	25	83.5	366	926	894.6
Enrolled nurse	581	675	1,038.5	96	10	100.7	485	665	937.8
Student nurse (incl. post-reg.)	1,183	—	1,183.0	174	—	174.0	1,009	—	1,009.0
Pupil nurse	522	46	556.8	37	—	37.0	485	46	519.8
Other nursing staff	816	2,516	2,439.3	99	21	111.9	717	2,495	2,327.4
Senior midwifery grades	60	3	61.6	—	—	—	60	3	61.6
Midwifery sister	141	57	177.2	—	—	—	141	57	177.2
Staff midwife	63	96	110.9	—	—	—	63	96	110.9
Pupil midwife	98	—	98.0	—	—	—	98	—	98.0

J. South Western R.H.B.

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	11,532	8,492	16,962.4	2,206	147	2,281.3	9,326	8,345	14,681.1
Senior nursing grades	795	29	813.3	218	1	218.5	577	28	594.8
Ward sister/charge nurse	1,922	513	2,260.0	580	4	582.5	1,392	509	1,677.5
Staff nurse	1,177	1,608	2,109.3	307	67	338.3	870	1,541	1,771.0
Enrolled nurse	1,660	1,487	2,675.9	349	18	357.5	1,311	1,469	2,318.4
Student nurse (incl. post-reg.)	2,337	—	2,337.0	379	—	379.0	1,958	—	1,958.0
Pupil nurse	1,176	69	1,227.5	114	—	114.0	1,062	69	1,113.5
Other nursing staff	1,704	4,528	4,627.2	259	57	291.5	1,445	4,471	4,335.7
Senior midwifery grades	118	4	120.6	—	—	—	118	4	120.6
Midwifery sister	264	96	323.7	—	—	—	264	96	323.7
Staff midwife	141	158	229.9	—	—	—	141	158	229.9
Pupil midwife	238	—	238.0	—	—	—	238	—	238.0

K. Birmingham R.H.B.

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	15,178	10,866	22,177·0	2,401	300	2,560·0	12,777	10,566	19,617·0
Senior nursing grades	924	43	950·8	308	2	309·0	616	41	641·8
Ward sister/charge nurse	2,469	871	3,024·9	667	14	672·8	1,802	857	2,352·1
Staff nurse	1,045	1,946	2,111·3	224	145	292·9	821	1,801	1,818·4
Enrolled nurse	2,192	1,918	3,502·6	318	35	336·3	1,874	1,883	3,166·3
Student nurse (incl. post-reg.)	3,088	—	3,088·0	523	—	523·0	2,565	—	2,565·0
Pupil nurse	1,791	62	1,837·3	165	—	165·0	1,626	62	1,672·3
Other nursing staff	2,526	5,671	6,314·6	196	104	261·0	2,330	5,567	6,053·6
Senior midwifery grades	141	1	141·2	—	—	—	141	1	141·2
Midwifery sister	340	188	452·8	—	—	—	340	188	452·8
Staff midwife	223	166	314·5	—	—	—	223	166	314·5
Pupil midwife	439	—	439·0	—	—	—	439	—	439·0

L. Manchester R.H.B.

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	16,446	10,253	22,754·4	2,717	220	2,834·4	13,729	10,033	19,920·0
Senior nursing grades	925	29	940·4	274	1	274·2	651	28	666·2
Ward sister/charge nurse	2,913	695	3,364·8	728	7	731·0	2,185	688	2,633·8
Staff nurse	1,135	2,081	2,243·6	221	114	276·8	914	1,967	1,966·8
Enrolled nurse	2,294	1,797	3,478·2	432	36	450·8	1,862	1,761	3,027·4
Student nurse (incl. post-reg.)	3,752	—	3,752·0	584	—	584·0	3,168	—	3,168·0
Pupil nurse	2,001	87	2,067·9	151	—	151·0	1,850	87	1,916·9
Other nursing staff	2,275	5,140	5,517·2	327	62	366·6	1,948	5,078	5,150·6
Senior midwifery grades	150	4	152·3	—	—	—	150	4	152·3
Midwifery sister	463	207	586·1	—	—	—	463	207	586·1
Staff midwife	167	213	280·9	—	—	—	167	213	280·9
Pupil midwife	371	—	371·0	—	—	—	371	—	371·0

M. Liverpool R.H.B.

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	8,884	5,754	12,494·3	1,419	133	1,488·7	7,465	5,621	11,005·6
Senior nursing grades	532	30	551·1	143	—	143·0	389	30	408·1
Ward sister/charge nurse	1,485	641	1,879·5	380	6	382·7	1,105	635	1,496·8
Staff nurse	540	843	1,011·3	148	41	166·7	392	802	844·6
Enrolled nurse	1,383	1,225	2,198·6	246	20	256·6	1,137	1,205	1,942·0
Student nurse (incl. post-reg.)	2,199	—	2,199·0	266	—	266·0	1,933	—	1,933·0
Pupil nurse	1,041	91	1,107·7	84	—	84·0	957	91	1,023·7
Other nursing staff	1,211	2,741	2,947·9	152	66	189·7	1,059	2,675	2,758·2
Senior midwifery grades	74	3	76·2	—	—	—	74	3	76·2
Midwifery sister	184	105	248·9	—	—	—	184	105	248·9
Staff midwife	63	75	102·1	—	—	—	63	75	102·1
Pupil midwife	172	—	172·0	—	—	—	172	—	172·0

N. Wessex R.H.B.

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	7,085	5,123	10,270.9	1,242	115	1,304.3	5,843	5,008	8,966.6
Senior nursing grades	494	22	506.8	135	—	135.0	359	22	371.8
Ward sister/charge nurse	1,177	161	1,282.8	320	2	321.0	857	159	961.8
Staff nurse	755	1,296	1,483.3	177	61	205.2	578	1,235	1,278.1
Enrolled nurse	914	818	1,480.4	183	14	192.4	731	804	1,288.0
Student nurse (incl. post-reg.)	1,483	—	1,483.0	249	—	249.0	1,234	—	1,234.0
Pupil nurse	804	80	864.6	64	1	64.8	740	79	799.8
Other nursing staff	987	2,586	2,609.8	114	37	136.9	873	2,549	2,472.9
Senior midwifery grades	62	—	62.0	—	—	—	62	—	62.0
Midwifery sister	169	19	179.1	—	—	—	169	19	179.1
Staff midwife	85	141	164.1	—	—	—	85	141	164.1
Pupil midwife	155	—	155.0	—	—	—	155	—	155.0

TABLE 5

NURSING AND MIDWIFERY STAFF IN TEACHING HOSPITALS AT 30 SEPTEMBER 1971
—ANALYSIS BY GRADE, SEX, AND NATURE OF CONTRACT

A. London undergraduate teaching hospitals

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	13,247	1,622	14,308.7	347	46	366.4	12,900	1,576	13,942.3
Senior nursing grades	618	14	627.2	45	—	45.0	573	14	582.2
Ward sister/charge nurse	1,347	91	1,407.5	54	—	54.0	1,293	91	1,353.5
Staff nurse	1,992	547	2,339.7	67	24	78.3	1,925	523	2,261.4
Enrolled nurse	977	306	1,188.9	55	7	59.0	922	299	1,129.9
Student nurse (incl. post-reg.)	5,966	—	5,966.0	73	—	73.0	5,893	—	5,893.0
Pupil nurse	707	19	722.2	22	—	22.0	685	19	700.2
Other nursing staff	949	559	1,310.7	31	15	35.1	918	544	1,275.6
Senior midwifery grades	66	—	66.0	—	—	—	66	—	66.0
Midwifery sister	171	18	182.1	—	—	—	171	18	182.1
Staff midwife	274	68	318.4	—	—	—	274	68	318.4
Pupil midwife	180	—	180.0	—	—	—	180	—	180.0

B. London post-graduate teaching hospitals

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	3,705	682	4,170.9	204	24	219.0	3,501	658	3,951.9
Senior nursing grades	223	8	228.0	19	1	19.8	204	7	208.2
Ward sister/charge nurse	500	32	525.2	49	—	49.0	451	32	476.2
Staff nurse	664	261	843.3	38	12	45.6	626	249	797.7
Enrolled nurse	505	122	594.6	41	4	43.7	464	118	550.9
Student nurse (incl. post-reg.)	1,044	—	1,044.0	33	—	33.0	1,011	—	1,011.0
Pupil nurse	159	—	159.0	2	—	2.0	157	—	157.0
Other nursing staff	439	242	593.2	22	7	25.9	417	235	567.3
Senior midwifery grades	19	—	19.0	—	—	—	19	—	19.0
Midwifery sister	38	1	38.8	—	—	—	38	1	38.8
Staff midwife	35	16	46.8	—	—	—	35	16	46.8
Pupil midwife	79	—	79.0	—	—	—	79	—	79.0

C. Provincial teaching hospitals

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	9,147	3,633	11,299.3	251	24	262.3	8,896	3,609	11,037.0
Senior nursing grades	420	16	429.5	31	—	31.0	389	16	398.5
Ward sister/charge nurse	1,162	287	1,354.0	54	1	54.6	1,108	286	1,299.4
Staff nurse	1,210	1,089	1,785.3	24	10	26.6	1,186	1,079	1,758.7
Enrolled nurse	590	534	935.0	43	1	43.5	547	533	891.5
Student nurse (incl. post-reg.)	3,744	—	3,744.0	70	—	70.0	3,674	—	3,674.0
Pupil nurse	583	77	637.8	11	—	11.0	572	77	626.8
Other nursing staff	619	1,505	1,516.4	18	12	25.6	601	1,493	1,490.8
Senior midwifery grades	88	5	90.5	—	—	—	88	5	90.5
Midwifery sister	201	33	223.8	—	—	—	201	33	223.8
Staff midwife	143	87	196.0	—	—	—	143	87	196.0
Pupil midwife	387	—	387.0	—	—	—	387	—	387.0

TABLE 6

NURSING AND MIDWIFERY STAFF AT 30 SEPTEMBER 1971—ANALYSIS BY GRADE, SEX AND NATURE OF CONTRACT

Wales

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	12,374	6,331	16,443.3	1,772	101	1,821.2	10,602	6,230	14,622.1
Senior nursing grades	783	24	799.5	153	—	153.0	630	24	646.5
Ward sister/charge nurse	1,878	297	2,076.1	458	1	458.2	1,420	296	1,617.9
Staff nurse	1,142	1,645	2,109.2	203	64	232.1	939	1,581	1,877.1
Enrolled nurse	1,821	1,199	2,621.8	214	12	220.7	1,607	1,187	2,401.1
Student nurse (incl. post-reg.)	2,412	—	2,412.0	401	—	401.0	2,011	—	2,011.0
Pupil nurse	1,139	35	1,164.4	111	—	111.0	1,028	35	1,053.4
Other nursing staff	2,517	2,885	4,431.4	232	24	245.2	2,285	2,861	4,186.2
Senior midwifery grades	91	—	91.0	—	—	—	91	—	91.0
Midwifery sister	264	82	313.4	—	—	—	264	82	313.4
Staff midwife	155	164	252.5	—	—	—	155	164	252.5
Pupil midwife	172	—	172.0	—	—	—	172	—	172.0

TABLE 7

NURSING AND MIDWIFERY STAFF AT 30 SEPTEMBER 1971—ANALYSIS BY GRADE, SEX AND NATURE OF CONTRACT

Scotland

	Total			Male			Female		
	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE	No. W/T	No. P/T	Total WTE
Total nursing and midwifery	29,805	16,356	39,938	4,251	104	4,315	25,554	16,252	35,623
Senior nursing grades	1,428	67	1,476	389	1	389	1,039	66	1,087
Ward sister/charge nurse	4,006	549	4,371	1,072	1	1,072	2,934	548	3,299
Staff nurse	2,577	3,599	4,633	522	63	559	2,055	3,536	4,074
Enrolled nurse	3,837	2,034	5,167	551	6	555	3,286	2,028	4,612
Student nurse (incl. post-reg.)	6,359	—	6,359	939	—	939	5,420	—	5,420
Pupil nurse	2,959	109	3,040	229	—	229	2,730	109	2,811
Other nursing staff	6,203	9,362	12,098	549	33	572	5,654	9,329	11,526
Senior midwifery grades	248	7	253	—	—	—	248	7	253
Midwifery sister	554	82	607	—	—	—	554	82	607
Staff midwife	592	547	892	—	—	—	592	547	892
Student midwife	1,042	—	1,042	—	—	—	1,042	—	1,042

TABLE 8

SUMMARY OF LOCAL AUTHORITY COMMUNITY HEALTH NURSING STAFF AT
30 SEPTEMBER 1971

	<i>Whole-time equivalents</i>						
	<i>London boroughs</i>	<i>E. & W. county boroughs</i>	<i>E. & W. county councils</i>	<i>Scotland counties</i>	<i>Scotland large burghs</i>	<i>Scotland cities</i>	<i>Total Great Britain</i>
Total nursing staff	4,018	8,106	14,059	1,453	465	917	29,018
Administrative	255	436	458	81	32	131	1,393
Health visitors	957	1,797	3,475	} 517	187	345	8,184
Health visitor trainees	197	280	428				
Home nurses (including trainees)	1,383	2,806	5,573	480	165	362	10,769
Domiciliary midwives	372	1,335	2,672	} 344	64	50	5,847
Midwifery pupils	220	436	354				
Other qualified	364	537	617	9	5	4	1,534
Other staff	270	479	482	22	12	25	1,291

APPENDIX V

THE DEMANDS ON RESOURCES WHICH THE RECOMMENDATIONS WILL MAKE

1. It is not possible generally to predict, except within wide limits, the demands which our recommendations would make on resources of manpower and money. The factors which will affect these demands can, however, often be identified and these are set out below, accompanied by estimates or by indications of outside limits of the likely calls on resources where it has been felt that these could be made with some degree of confidence.

2. The recommendations which call for additional resources are many, but fall into three broad groups:

- (a) those relating to changes in the organisation and staffing of schools themselves;
- (b) those relating to recruitment and to hours of work and conditions
- (c) those relating to the actual operation of the proposed new form of nursing and midwifery education.

Most of the recommendations, in particular those in groups (a) and (b), involve only a slight modification to existing policies but the progress in implementing some of these policies would have to be accelerated; others would require new measures.

CHANGES IN THE ORGANISATION AND STAFFING OF SCHOOLS

3 (a). *Accelerated grouping of nursing and midwifery training centres into Colleges*

Grouping, which was already the policy of the General Nursing Councils was accelerated by the introduction of the Salmon structure and most hospital groups now have Group Training Schools. The 1974 National Health Service reorganisation will facilitate the organisation of schools on a District basis. It is likely that existing group school buildings and those already planned will be used and little additional cost is envisaged in implementing this recommendation.

(b). *Establishment of Colleges of Health Service Studies*

Here again, existing buildings, including group Education Centres, will probably be used and substantial additional expenditure on buildings is unlikely, except for adaptations and some equipment.

(c). *Provision of more qualified teachers of nursing and midwifery*

The Committee has not found it possible to define a ratio of tutors to students and pupils or, in future, of lecturers to students. But over the transitional period, on the assumption that there should be one qualified tutor to thirty students/pupils, and regarding three hundred tutors as being engaged largely on school administration, over 2,600 tutors could well be needed by 1979 when a major development of

post-Registration courses would begin. At present there are about 1,950 of whom 1,350 are qualified. By 1979 existing courses would probably have increased the number of qualified tutors to sixteen hundred. New courses at present being explored might increase this to 1,750. In order to meet the likely requirement, twice the present number of courses could well be needed to train new tutors. In addition, courses would be required to enable the present unqualified tutors to qualify. But new courses are difficult to establish and it may be that the fact that the number of suitably qualified and experienced nurses and midwives who are interested, and whom the hospitals and community can release, is obviously limited, will prove to be the main restriction on development. These additional tutors can come only from existing qualified nurses and midwives and do not represent additional manpower.

It seems quite possible that over two thousand clinical teachers will also be necessary, certainly while the tutor force is being built up. At the moment there are about eight hundred but with only a slight expansion, the present courses could meet the demand up to the late 1970's. These clinical teachers will also have to be drawn from nurses and midwives qualified now or qualifying in the next two or three years.

(d). Experimental training schemes

It is not expected that the net additional cost of these experiments will be great, since, as they are being introduced, existing specially financed modular schemes will be ending. Their cost should only be for evaluation, as the additional costs arising from increased tutorial staff and replacement staff, etc., are those common to all schemes on the proposed system and are dealt with elsewhere in this Appendix.

(e). Additional research

Additional resources, both in terms of manpower and money, will be required and in practice it is the availability of suitably qualified people which is likely to put the effective limit on the work which can be done in the short run.

(f). Educational records

There will be additional cost in money and manpower arising both centrally and at Colleges from the need to record the modules covered by a student both initially and on movement from one field to another, but it is not possible to estimate this cost with any certainty.

RECRUITMENT, HOURS OF WORK AND CONDITIONS

4 (a). National recruitment campaigns for particular categories of staff

Particular categories for which recruitment activity should be increased include mature entrants and those returning to nursing and midwifery, men and graduates. It is not possible to estimate the cost of such increased recruitment activity until campaign planning has been considered in some depth.

(b). Improvements in relation to hours of work

The improvements include revision of shift systems, reduction of abuse of night duty and clarification of "on-call" systems. None can be regarded strictly as part of the cost of the Committee's recommendations as improvements of this

kind form a normal part of the process of change and of negotiations with staff representatives, both nationally and locally.

(c). Improvements in conditions of work

These concern the fuller use of existing provision for study leave and the use of assisted transport. The cost of the extension of these existing provisions will depend on take-up.

(d). Upgrading and standardising of accommodation

The cost of this can only partly be attributed to this Committee's recommendations. A study is at present being made of accommodation for nursing staff and presumably the result of this will determine what upgrading is necessary and therefore to some extent its cost; at this stage the cost cannot be estimated. The cost of upgrading may well be indirectly affected by other recommendations of the Committee, but it is not possible to forecast the nature of the overall effect. For example, early Certification might intensify the trend towards living out. On the other hand, the effects of wider secondment between hospitals, and between hospitals and the community, might lead to a need for more residential accommodation, since living out is only really practicable if most of the training takes place within easy daily travelling distance of home.

(e). Development of manpower units, personnel departments and counselling services

The development of personnel departments has already started and its general progress is seen by the Committee as part of National Health Service reorganisation. The appointment of nurses and midwives to undertake nursing and midwifery personnel duties in a staff capacity is a Committee recommendation and has only started on a small scale in association with the development of the Salmon structure. In addition to the cost of extending such appointments the expansion of functions envisaged by the Committee for manpower and personnel departments could give rise to substantial additional expenditure. Counselling already forms part of the normal duties of nursing and midwifery teams in hospital and community and of the tutorial staff of training schools. To the extent that counselling services became more sophisticated requiring coordination at Area Health Authority/Board level, this could give rise to additional annual expenditure.

CHANGES IN NURSING AND MIDWIFERY EDUCATION

(a). Reduction of age of entry to seventeen

The net effect of this change, to be accomplished in two stages, is difficult to judge. Over the years it should widen the field of selection and possibly increase recruitment. Some young women and men who have hitherto not been able to wait until the age of eighteen and have taken alternative jobs have been permanently lost to nursing; these may now join the profession. But it is not likely that there will be a very large once for all "hump" in total recruitment at each lowering of the age of entry, for many applicants will merely be diverted from one of the special trainings—ophthalmic, orthopaedic or thoracic—to general or psychiatric training. No great increase in cost is therefore expected.

(b). *Overseas trainee nurses*

The only recommendation relating to overseas trainee nurses which is expected to involve significant additional costs is that on orientation courses. The courses themselves would probably not be costly, as many of the lectures would probably be given by hospital staff or voluntarily by members of the local community. Assuming that only those students recruited in their country of birth would need an orientation course, it is estimated that between 3,500 and four thousand students per year would need a three-week course. There might also be some accommodation costs.

(c). *Introduction of the proposed new system of training*

In trying the effects of the proposals in model form, it does not appear that any insuperable allocation difficulties would arise, although a great deal of planning and adjustment may be necessary to ensure that swings in staffing are avoided. The system would probably be no easier to operate than a good traditional system, using concurrent theory and practice as its basis. We think it will be necessary to have more than two intakes per year in many Colleges. It is quite clear that the system will work only if the staff of the College and the service staff of the participating hospitals work closely and continuously together.

The system proposed is very flexible, permitting schools and trainees a wide range of options. This has great advantages but it is almost impossible to estimate the additional manpower and money required. Some indication can, however, be given of the manpower requirements, given certain assumptions.

Annual intake. Tests carried out by the General Nursing Council (for England and Wales) Research Unit suggest that if the suggested new entry qualifications were applied about nine hundred of the present annual intake might not qualify for selection. On the other hand this could be offset in part by the lower age of entry and by what we expect to be the greater attraction of the new form of training.

Additional Staff. By comparing the service given by present enrolled nurses, students and pupils with that which we estimate would be given by pre-Certificate and pre-Registration students and by post-Certificate nurses not proceeding to Registration, we have concluded that some eleven thousand additional staff might be required by the end of 1979, when the scheme could be fully implemented. Part of this, perhaps two thousand to three thousand staff, will in any case be required if the General Nursing Council's 1969 syllabus is to be implemented by 1975, reducing the manpower necessary specifically to meet our recommendations. The estimate must be taken only to give a broad indication of the possible increase.

6. Our estimates indicate that while the general field would require extra staff, the psychiatric hospitals would gain; the figure we give is net, offsetting the psychiatric gain against the additional staff in the general field. In practice, this might not happen, any extra staff possibly being used to make good shortages in psychiatric hospitals. In manpower terms, this might increase the additional staff employed to about 14,500, but the extra 3,500 staff would represent improvement of the nursing service in psychiatric hospitals rather than a direct and necessary consequence of the Committee's education proposals.

7. Many assumptions are involved in these estimates. For example, we assumed no increase in recruitment and no change in present wastage rates, though we hope the latter will decline. We have postulated that thirty per cent of students will not

continue their education beyond the Certificate stage; if this guess—for it is little more—is wrong, and forty per cent of nurses stop at the Certificate stage, the number of replacement staff is likely to be reduced by about one thousand. If Certificated nurses were retained, as mature entrants might well be, for long service, the intake of students would ultimately be forced down. The assumption has also been made that forty per cent of post-Certificate students would take the Higher Certificate course; if this figure were increased to fifty per cent we estimate that up to eight hundred more replacement staff could be needed.

It has also been assumed that twenty-five per cent of “general” post-Certificate students would take the community option; the amount of experience available is likely to be a limiting factor here and a reduction to ten per cent of those taking this option would, we estimate, reduce the replacement staff by about one thousand.

Mature students on part-time courses would give rise to a demand for additional replacement staff, but not on a large scale. The small number of pupil midwives who have not taken any form of nursing training would, if they entered midwifery under our proposals via the Certificated nurse course, create a small additional training demand.

Secondments. The system will call for increased secondments of students and qualified staff and possibly for more use of residential accommodation as a result, but it is not possible to assess the extent or cost of these developments.

Education schemes for auxiliaries and assistants. There will be some additional cost on extending the coverage of existing training schemes. These already cover the nursing assistants in many psychiatric hospitals and are being developed in general hospitals, for nursing auxiliaries. The cost in manpower and money is not likely to be great.

ASSIMILATION

8. Recognition of qualifications will be for the new statutory body and should not in itself lead to extra costs. Recognition of expertise is a matter for the Nurses and Midwives Whitley Council and any cost arising from their consideration is not properly a cost of the Committee's recommendations. There would, however, presumably be an identifiable expense as the result of all nurses becoming Certificated after eighteen months.

GLOSSARY OF TERMS USED IN THE REPORT

The initials OS indicate that this is a category used in the Opinion Surveys and the Survey of Reserves of Nurses described in Appendix I.

ACUTE HOSPITALS (OS)—Acute, Mainly Acute and Partly Acute General Hospitals.

AGENCY MIDWIFE—A midwife employed on the basis of hire from a private employment agency.

AGENCY NURSE—A nurse employed on the basis of hire from a private employment agency.

ANCILLARY STAFF (NURSING) IN THE COMMUNITY—Persons who are employed by local health authorities on nursing duties who have no recognised nursing or midwifery qualification.

ASSIMILATION—The fitting of those holding obsolete grades and qualifications into a new system of grades and qualifications.

“BEST BUY” HOSPITALS—New district general hospitals built to a single design and planned as integral parts of the health and welfare services of the communities they serve.

BIRMINGHAM (OS)—Birmingham Regional Hospital Board area excluding hospitals categorised as Teaching Hospitals.

CENTRAL DEPARTMENTS—According to context, the Government Departments responsible for the particular field under discussion.

CENTRAL MIDWIVES BOARD—The Central Midwives Board or the Central Midwives Board for Scotland.

CLINICAL INSTRUCTOR—A clinical teacher registered by the G.N.C. (or, in Scotland, the C.M.B.).

CLINICAL TEACHER—A clinical instructor or teacher of pupil nurses (*q.v.*).

COMMUNITY MIDWIVES—State Certified Midwives employed by a local health authority.

COMMUNITY NURSES—Nurses employed by local health authorities.

C.M.B.—See CENTRAL MIDWIVES BOARD.

D.E.S.—The Department of Education and Science.

DEVELOPING COUNTRIES (OS)—West Indies and South America, Africa and Mauritius excluding South Africa, Malaysia, India, Pakistan and Middle East States not in Africa, excluding Israel, South-East Asia including the Philippines, but excluding Australia and New Zealand.

DEVELOPED COUNTRIES (OS)—Those countries outside the United Kingdom not classified as developing countries.

D.H.S.S.—The Department of Health and Social Security.

DISTRICT NURSE—A nurse employed by a local health authority in accordance with the National Health Service Act, 1946, and the Health Service and Public Health Act, 1968, to nurse persons who require nursing in their homes and elsewhere than in their homes.

DISTRICT NURSE TUTOR—A nurse employed to teach district nurses.

DOMICILIARY MIDWIVES—See COMMUNITY MIDWIVES.

EAST (OS)—Sheffield and East Anglian Regional Hospital Board areas excluding hospitals categorised as Teaching Hospitals.

EDUCATION DEPARTMENTS—The Department of Education and Science and the Scottish Education Department.

ENROLLED NURSE—State Enrolled Nurse (S.E.N.), Senior Enrolled Nurse, Enrolled Mental Nurse (S.E.N.(M.)) or Enrolled Nurse for the Mentally Sub-normal (S.E.N.(M.S.)).

FIELD WORK INSTRUCTOR—A health visitor recognised for the practical instruction of student health visitors.

FULL-TIME NURSES—Nurses in full-time employment working an 80-hour fortnight as laid down in Whitley Council Circular, NMC Circular No. 160.

GENERAL NURSING COUNCIL—The General Nursing Council for England and Wales or the General Nursing Council for Scotland.

G.N.C.—See GENERAL NURSING COUNCIL.

HEALTH DEPARTMENTS—The Department of Health and Social Security, Scottish Home and Health Department and Welsh Office.

HEALTH VISITOR—A nurse employed by a local health authority in accordance with the National Health Service Act, 1946, and the Health Service and Public Health Act, 1968, to visit persons in their homes and elsewhere than in their own homes to prevent the occurrence of illness and promote good health.

HEALTH VISITOR TUTOR—A health visitor employed to teach health visitors and holding a qualification recognised by the Council for the Education and Training of Health Visitors.

HOME NURSE—See DISTRICT NURSE.

HOSPITAL MIDWIFE (OS)—A midwife or pupil midwife employed by a Hospital Management Committee, Board of Governors or Board of Management.

HOSPITAL NURSES—Nurses employed by Hospital Management Committees, Boards of Governors or Boards of Management.

IMMIGRANT NURSES (OS)—Nurses born in a developing country, whose father was born in a developing country and who came to Britain after the age of sixteen.

INTERVIEW SURVEY—The Survey of Opinions of Nurses and Midwives conducted by personal interview (see Appendix I).

LOCAL AUTHORITY MIDWIVES—See COMMUNITY MIDWIVES.

LOCAL AUTHORITY NURSES—See COMMUNITY NURSES.

LONG-STAY HOSPITALS (OS)—Mainly and Partly Long-Stay Hospitals, Chronic Hospitals.

MENTAL HANDICAP HOSPITALS (OS)—Mental Handicap and Mental Deficiency Hospitals.

MENTAL ILLNESS HOSPITALS (OS)—Hospitals for the mentally ill.

METROPOLITAN (OS)—North West, North East, South East and South West Metropolitan Regional Hospital Board areas excluding hospitals categorised as Teaching Hospitals.

MIDWIFE—State Certified Midwife (S.C.M.).

MIDWIFE TEACHER—A teacher of midwives holding the Midwife Teacher's Diploma.

MIDWIVES (OS)—Midwives and pupil midwives.

NORTH EAST (OS)—Newcastle and Leeds Regional Hospital Board areas excluding hospitals categorised as Teaching Hospitals.

NORTH WEST (OS)—Manchester and Liverpool Regional Hospital Board areas excluding hospitals categorised as Teaching Hospitals.

NURSES (OS)—Registered nurses, enrolled nurses, student nurses, post-registration student nurses, pupil nurses, nursing auxiliaries and assistants.

NURSE TUTOR—A registered nurse tutor.

NURSING ASSISTANT—A Nursing Auxiliary as defined below, but working in a psychiatric hospital.

NURSING AUXILIARY—A person engaged on nursing duties other than in a psychiatric hospital, who has no recognised nursing or midwifery qualification and who is not a student nurse, pupil or student midwife or pupil nurse.

O.P.C.S.—The Office of Population Censuses and Surveys.

OPINION SURVEYS—The Surveys of Opinions of Nurses and Midwives described in Appendix I.

OTHER HOSPITALS (OS)—Preconvalescent, convalescent, rehabilitation, isolation, maternity, orthopaedic, TB, chest, isolation and eye hospitals, children's acute, clinics, other hospitals and establishments. Where classification is into Acute/Psychiatric/Other, Long-Stay hospitals are also included in Other.

OTHER LOCAL AUTHORITY STAFF (OS)—Nursing Staff employed by local health authorities, other than Senior Staff, Health Visitors, District Nurses and Midwives.

OVERSEAS NURSES (OS)—Nurses born overseas, whose father was born overseas and who came to Britain after the age of sixteen.

PARTICIPATION RATE—The percentage number of persons in any given population who are in employment or registered as available for employment.

PART-TIME NURSES—Nurses in part-time employment working any number of hours less than 80 per fortnight.

POSTAL SURVEY—The Survey of Opinions of Nurses and Midwives conducted by Postal Questionnaire (see Appendix I).

POST-REGISTRATION STUDENT NURSE—A registered nurse training for an additional part of the register.

PRACTICAL WORK INSTRUCTOR—A district nurse recognised for practical district instruction.

PSYCHIATRIC—Adjective embracing mental illness and mental handicap, sub-normality or deficiency.

PSYCHIATRIC HOSPITALS (OS)—Mental Illness, Mental Handicap and Mental Deficiency Hospitals.

PUPIL MIDWIFE (ENGLAND AND WALES)—A person undergoing training for the Roll of Midwives in accordance with the rules of the Central Midwives Board.

PUPIL NURSE—A person undergoing training for the Roll of Nurses in accordance with the rules of the General Nursing Council.

QUALIFIED NURSES (OS)—All registered or enrolled nurses or certified midwives employed on nursing or midwifery duties by Hospital Management Committees, Boards of Governors or Boards of Management, or by local health authorities, within Great Britain.

REGISTER—The Register of Nurses kept by the General Nursing Councils.

REGISTERED NURSE—State Registered Nurse (S.R.N.), Registered General Nurse (R.G.N.), Registered Mental Nurse (R.M.N.), Registered Nurse for the Mentally Subnormal (R.N.M.S.), Registered Nurse for Mental Defectives (R.N.M.D.), Registered Sick Children's Nurse (R.S.C.N.), or Registered Fever Nurse (R.F.N.).

ROLL—The Roll of Nurses kept by the General Nursing Councils or the Roll of Midwives kept by the Central Midwives Board.

SCOTLAND (OS)—All hospitals in Scotland.

S.E.D.—The Scottish Education Department.

SENIOR COMMUNITY NURSES (OS)—All nurses employed by local health authorities who categorised themselves above the rank of Health Visitor or District Nurse.

SENIOR HOSPITAL NURSES (OS)—All hospital nurses who categorised themselves above the rank of Sister or Charge Nurse.

S.H.H.D.—Scottish Home and Health Department.

SISTER (OS)—Senior Night Sister or Charge Nurse, Night Sister or Charge Nurse, Departmental Sister or Charge Nurse, Ward Sister or Charge Nurse, Home Sister or Housekeeping Sister, Midwifery Sister. In the opinion surveys Midwifery Sisters were included under Midwives.

SOUTH AND WEST RURAL (OS)—Oxford, South Western and Wessex Regional Hospital Board areas excluding hospitals categorised as Teaching Hospitals.

STAFF NURSE (OS)—A registered nurse below the rank of Sister employed in a hospital, a staff midwife. In the opinion surveys, staff midwives were included under Midwives.

STUDENT MIDWIFE (SCOTLAND)—See PUPIL MIDWIFE (ENGLAND AND WALES).

STUDENT NURSE—A person who is undergoing training for admission to any part of the Register of Nurses in accordance with the rules of the General Nursing Council, including post-registration student nurses (*q.v.*).

SURVEY OF RESERVES OF NURSES—The Survey of Nurses and Midwives not currently employed as nurses or midwives in the National Health Service (see Appendix I).

TEACHER OF PUPIL NURSES—A teacher of pupil nurses registered by the G.N.C.

TEACHING HOSPITALS (OS)—English and Welsh Teaching Groups under an independent Board of Governors but excluding Scottish teaching hospitals and University Hospital Management Committees.

TRAINEE NURSES (OS)—All student nurses, pupil nurses, post-registration student nurses and student or pupil midwives.

TURNOVER RATE—The percentage number of persons in any given population of employees who leave that employment in a given time period.

TUTOR—See NURSE TUTOR.

WALES (OS)—Welsh Hospital Board area excluding hospitals categorised as Teaching Hospitals.

WASTAGE RATE—The percentage number of persons in any given occupational group who leave that occupation in a given time period.

WHITLEY COUNCIL—The Nurses and Midwives Whitley Council, Great Britain.

WHOLE-TIME EQUIVALENT (W.T.E.)—Whole-time equivalent of whole-time and part-time nurses. Whole-time equivalent of part-time is calculated by dividing the total number of hours actually worked per fortnight by the number of hours in the standard working fortnight. The total whole-time equivalent is then obtained by adding this number to the number of whole-time nurses.

WHOLE-TIME NURSES—See FULL-TIME NURSES.

W.O.—The Welsh Office.

W.T.E.—See WHOLE-TIME EQUIVALENT.

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